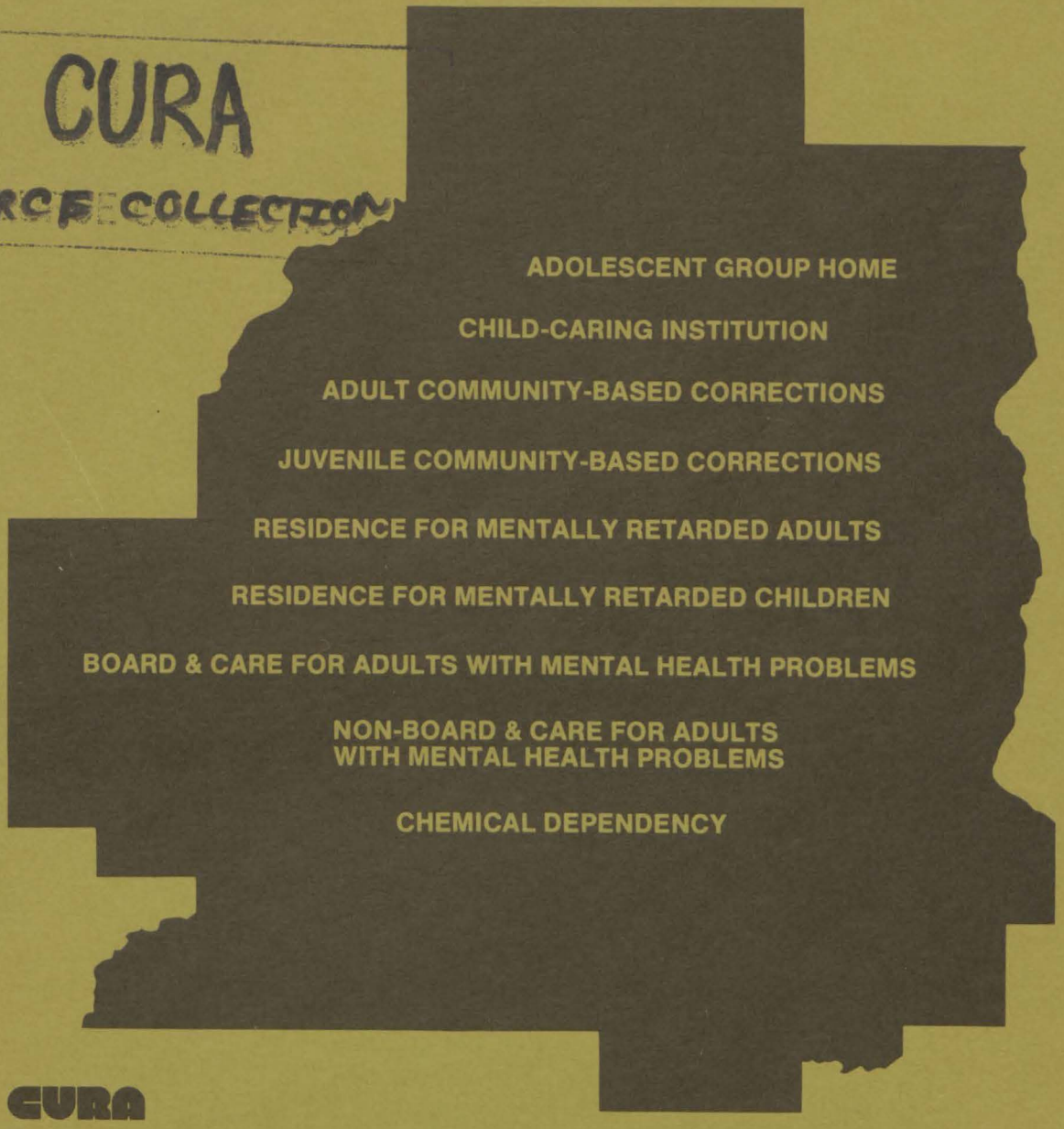
COMMUNITY-BASED RESIDENTIAL FACILITIES IN THE TWIN CITIES METROPOLITAN AREA

Location and Community Response



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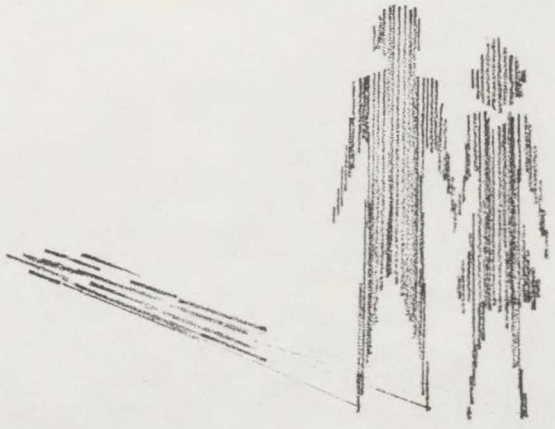

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Introduction

This study of the growth and development of "community-based residential facilities" within the Minneapolis-St. Paul metropolitan area reflects an on-going interest of the Center for Urban and Regional Affairs (CURA), University of Minnesota, in examining questions related to both metropolitan land use, and innovation in the delivery of human services. Some people view these facilities as the principal alternative to ineffective and costly institutionalization of persons with physical, emotional, or social disabilities. For others, the community-based residential facility, e.g. group home, halfway house, et. al. is an adverse form of land use, contributing to and associated with negative consequences for the community in which it is located. It is argued that these two positions represent an inherent structural conflict between the planning and allocation of resources to community-based residential facilities at the County and regional level and local municipal attempts to control the development of these facilities through land use and zoning practices.

This paper first presents a typology of residential facilities describing the extent of these facilities in the Twin Cities metropolitan area in Fall 1975. A systematic identification and discussion of different types of community resistance to residential facilities examining the implications of this resistance for further program development follows. Over forty cases in the Twin Cities metropolitan area have been examined.

Finally, ways in which planning for community-based residential facilities may be enhanced are identified and recommendations for future discussion and action by relevant decision-makers are outlined.

PART 1 : Classification and Locational Description of Community-Based Residential Facilities

The primary stimulus to the increased growth and development of community-based residential services has been the movement toward "de-institutionalization", that is, experimentation with alternative living and therapeutic arrangements to traditional public total institutions (prisons, state hospitals, reformatories, et.al.). The following statistics illustrate this movement in Minnesota:

-- From 1970 to June 30, 1975, the population of mentally ill persons in state institutions decreased from 3124 to 1635.[1]

-- During the same period, the population of mentally retarded persons in state institutions decreased from 4589 to 3431.[1]

-- From 1970 through 1974, the population of offenders in the Minnesota State Prison and Minnesota State Reformatory for Men decreased from 1674 to 1207.[2]

A full discussion of the causes leading to these decreases is beyond the scope of this paper. However, as Lauber and Bangs note:

> ...movement toward deinstitutionalization and community care has been spurred on by the increasing awareness among professionals that generally large institutions have not worked: they have not, in the case of the mentally ill, helped people get well; they have not, in the case of the mentally retarded, helped people to learn and improve their functioning; nor in the case of offenders, have they taught them to lead non-criminal lives.[3]

As described by the Minnesota State Planning Agency, the following assumptions are basic to the movement toward deinstitutionalization:

1. Confinement in state facilities is an ineffective and expensive approach to treatment;
2. Confinement should be de-emphasized as an approach to treatment;
3. Treatment should be decentralized to locations more accessible to client populations;
4. Local jurisdictions (e.g.,regions, sub-regions, counties, etc.) should share in and eventually assume responsibility for local problems and subsequently treatment programs;

5. Funding incentives should be reversed to encourage treatment through local programs rather than through traditional state institutions; and

6. State institutions should eventually be closed down or turned over to the management and control of local jurisdictions.[4]

Whether the community-based residential facility serves primarily as a permanent residence, e.g., group homes for mentally retarded persons, or is used for transitional purposes, e.g., halfway house for chemically dependent persons, these underlying assumptions seem to apply. As such, regardless of the specific target group served, all community-based residential facilities can be conceived as constituting a "normalization services system."

Two important concepts are related to deinstitutionalization: "normalization" and "continuum of care." As defined by Bengt, and most often associated with the care and treatment of developmentally disabled persons,

> ...the normalization principle means making available to the mentally retarded, patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society.[5]

"Normalization" implies that standards for residences serving as community-based residential facilities should be the same as those regularly applied to similar dwellings for ordinary citizens. In other words, community-based residential facilities are not institutions, rather they function as "home" for their occupants.

Derived from Federal social services policies, the concept of "continuum of care" has as its objective enabling persons to move from states of physical, emotional, and/or financial dependency to states of self-sufficiency and/or self-support.[6] A "continuum of care" for mental health residential facilities is presented in Figure 1.

Residential programs are a component of a larger services system. Similarly, in the treatment of chemical dependency problems, the existence

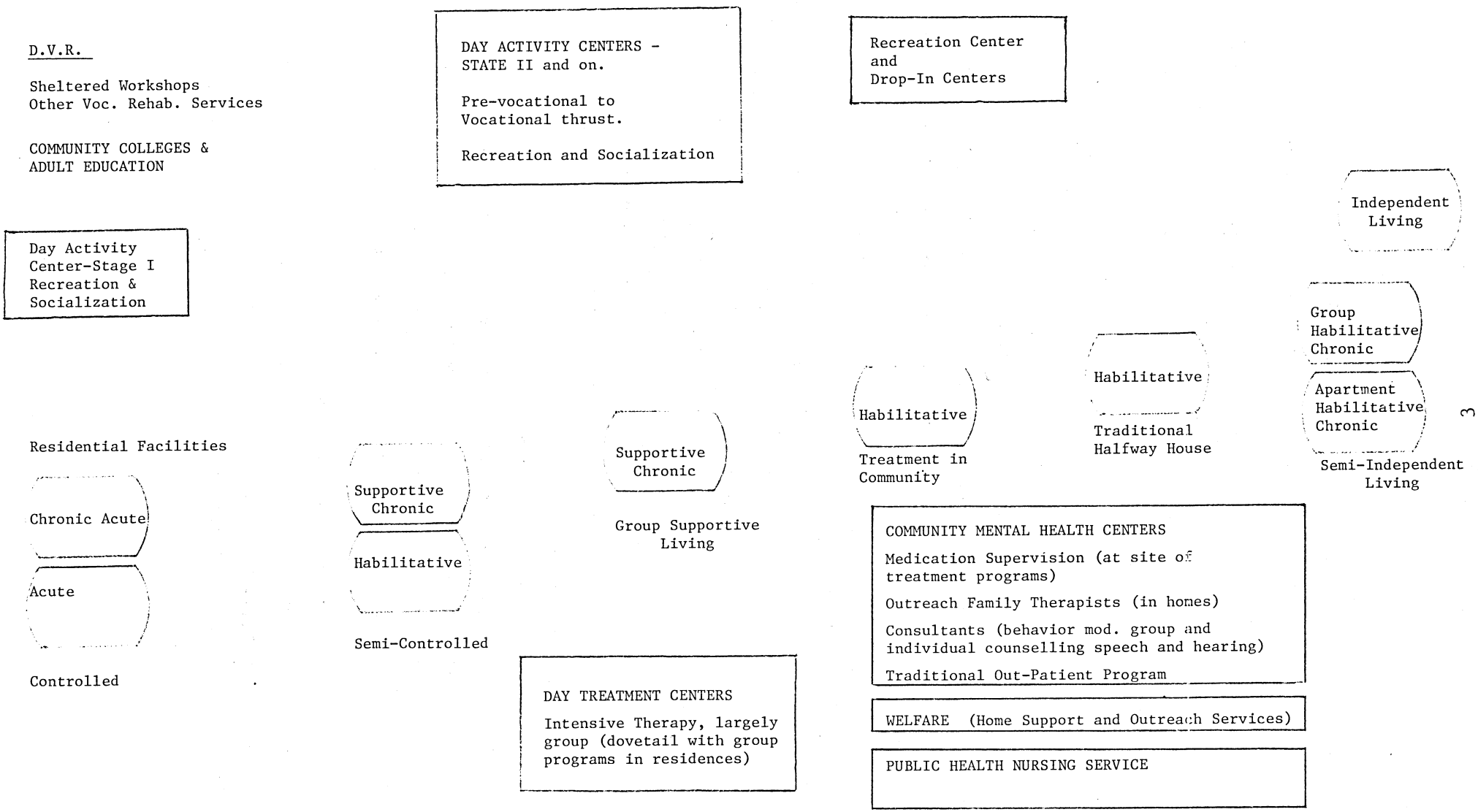


FIGURE 1: A Continuum of Care for Mental Health Residential Facilities [7]

of quarter-way, halfway, and three-quarter-way houses directly depends on case finding, detoxification, and primary rehabilitation services. Imbedded in a network of essential support services, the residential facility provides a transition to independent living.

Beyond this link between the community-based residential facility and the institution, which is embodied in the concept of deinstitutionalization, there is little consensus on how to best define the "community-based residential facility." The American Society of Planning Officials notes that:

> Family and group care facilities serve members of five basic groups:
>
> -- the homeless, mistreated, or abused child
> -- the mentally ill
> -- the mentally retarded
> -- the criminal offender
> -- the alcoholic and other drug abusers[3]

However, ASPO further observes: "Due to their great variety, the different family and group care facilities are difficult to define accurately and adequately."

In developing a way to categorize community-based residential facilities that is relevant for planning purposes, local and state program planning activities and licensing rules must be considered. The typology of community-based residential facilities presented in Table 1 is exhaustive of the 247 facilities listed in Appendix A.

TABLE I

TYPOLOGY OF COMMUNITY-BASED RESIDENTIAL FACILITIES

TYPE	DEFINITION
1. Adolescent Group Home --Subtypes a) by sex -- male, female, coed b) by age -- pre-teen (8-12), early teen (13-14), mid or late teens (15-18) c) by status -- ethnic group, e.g., Native American; problem identification, e.g., "aggressive behavior", "adjustment problems", "preparation for independent living", et. al.	A specialized facility that provides care on a 24 hour/day basis for a selected group of not more than 10 children under the age of sixteen.[8]
2. Child-caring "Institution" --Subtypes a) by status -- emotionally disturbed children, delinquent children, single parent residential programs, women's emergency residential programs.	A facility for the care and treatment of children, providing shelter, food, training, treatment, and other aspects of care for more than 10 children on a 24-hour basis.[9]
3. Adult Community Corrections --Subtypes a) by sex -- male, female, coed b) by status -- ethnic group, e.g., Native American, problem identification, e.g., chemical dependency; type of offense, e.g., property offense.	A) Halfway House: A residential facility designed to facilitate the transition of paroled adult ex-offenders who are referred from institutional confinement.[10] B) P.O.R.T. Project: (Probationed Offenders Rehabilitation and training), a residential program designed for adult offenders who have been sentenced to state institutions, have had their sentences suspended or stayed, and have been placed on probation, a condition of which is program participation.[10]
4. Juvenile Community Corrections --Subtypes a) by sex -- male, female, coed b) by age -- pre-teen (8-12), early teen (12-14), mid or late teens (15-18) c) by status -- ethnic group, e.g., Native American; problem identification, e.g., "aggressive behavior", adjustment problems", "preparation for independent living", et. al.	The intent of these facilities is to redirect the delinquent careers of their clients into non-delinquent channels. A) Group Residence: A residential facility designed for males or females, 14-18 years of age who have been incarcerated in a state institution.[10] B) Group Home: A residential facility designed for males or females, 14-18 years of age who are at the pre-adjudication or adjudication stages of involvement but have not yet been incarcerated.[10] (Governor's Commission on Crime Prevention and Control)
5. Chemical Dependency --Subtypes a) by sex -- male, female, coed b) by age -- adolescent (12-18), young adult (18-25), adult (18+) c) by status -- ethnic group, e.g., Native American; type of chemical abuse, e.g., alcohol only, polydrug use; state of recovery, e.g., quarter-way, half-way, three-quarter way. d) by treatment modality -- Alcoholics Anonymous model, Synanon/therapeutic community model.	A) Residential Primary Treatment Program: A social rehabilitation setting providing intensive rehabilitation services for the treatment of 5 or more inebriate or drug dependent persons.[11] B) Extended Rehabilitation Program: A social rehabilitation setting providing long-term assistance in major life-style changes through a therapeutic milieu with highly specialized facilitative rehabilitation services to 5 or more inebriate or drug dependent persons.[11] C) Halfway House: A social rehabilitation setting providing assistance in making transition from treatment to responsible community living in a supportive environment with a home-like atmosphere for 5 or more inebriate or drug dependent persons.[11]
6. Residences for Mentally Retarded Persons --Subtypes a) by age -- children (0-12), adolescents (13-18), adults (18+) b) by sex -- males, female, coed c) by functional/intellectual status -- ambulatory, non-ambulatory/physically handicapped; educably retarded (IQ 40-54), severely retarded (IQ 25-39), profoundly retarded (IQ below 25).	A facility in which there is provided supervision, lodging, meals, counseling and developmental habilitative or rehabilitative services to 5 or more persons who are mentally retarded. A) Class A Supervised Living Facilities: Includes homes for ambulatory and mobile persons who are capable of taking appropriate action for self-preservation under emergency conditions as determined by program licensure provisions, i.e., Rule #34, Department of Public Welfare.[12] B) Class B Supervised Living Facilities: Includes homes for ambulatory, non-ambulatory, mobile, or non-mobile persons who are not mentally or physically capable of taking appropriate action for self-preservation under emergency conditions as determined by program licensure provisions, i.e., Rule #34, Department of Public Welfare.[12]
7. Residences for Adults with Mental Health Problems --Subtypes a) by sex -- male, female, coed b) by functional status -- acute medically ambulatory persons requiring primarily psychosocial and rehabilitative services; medically ambulatory persons with chronic psychosocial disabilities not responsive to intensive intervention. c) by treatment modality -- (see "continuum of care", page 3), minimal intervention (board and care homes), therapeutic community, halfway house, Fairweather 'experiment' in work-living cooperative.	Any program which accepts for treatment/rehabilitation 5 or more mentally ill persons on a regular basis for more than 3 consecutive days.[13]

Appendix A lists facilities by geographical area. In total, 247 community-based residential facilities in the Twin Cities Metropolitan area have been identified. The classification of facilities conforms to the definitions contained in Table 1. Considerable functional overlap exists between facilities categorized as "adolescent group home", "child-caring institutions", and "juvenile community corrections". Facilities currently receiving primary financial support through the Governor's Commission on Crime Prevention and Control (L.E.A.A. funds), Ramsey County Community Corrections appropriations, or Anoka and Dakota County Court Services have been classified as "juvenile community-based corrections". For example, Zion Northside Group Home is licensed under DPW Rule #8 (adolescent group home) but receives its primary funding through the Governor's Commission on Crime Prevention and Control. It has been classified as a "juvenile community-based corrections" facility, not as an "adolescent group home".

"Child-caring institutions" represent facilities which primarily serve emotionally-disturbed children and juveniles with behavioral problems. A child-caring institution is distinguished from a group home on the basis of the intensity of its therapeutic program or the scale of its operations, i.e., having greater than 10 residents.

The inclusion in this study of board and care homes serving adults with mental health problems reflects their impending licensing under the Department of Public Welfare's Rule #36. Those board and care homes that acknowledge serving adults with mental health problems are included. For the most part, these facilities are certified as Intermediate Care Facilities under Title XIX (Medicaid). Additionally, many boarding and rooming houses located in the same geographical areas as these homes have significant numbers of residents with histories of mental illness. The extent to which this is the case, however, awaits further study.

The following maps show the spatial distribution of these facilities by type in the Twin Cities metropolitan area. Table 2 gives the number of facilities by type within Minneapolis, St. Paul, and suburban sectors.

TABLE 2

DISTRIBUTION OF COMMUNITY-BASED RESIDENTIAL FACILITIES BY TYPE

			SUBURBAN SECTORS								
Type	Mpls	St. Paul	N. Mpls	S. Mpls	SW Mpls	NW Mpls	N. St. Paul	NE St. Paul	SE St. Paul	S. St. Paul	TOTAL
Adolescent Group Home	21	8	4	1	4	2	-	2	3	-	45
Child-caring Institution	3	13	1	-	-	-	1	-	-	-	18
Adult Community-based Corrections	11	5	-	-	-	-	-	-	-	-	16
Juvenile Community-based Corrections	4	15	8	1	-	-	10	15	1	2	56
Residence for Mentally Retarded Adults	9	4	1	1	1	1	-	1	-	2	20
Residence for Mentally Retarded Children	1	3	-	-	3	1	1	1	-	1	11
Board & Care for Adults with Mental Health Problems	14	17	-	-	-	-	-	-	-	-	31
Non-Board & Care for Adults with Mental Health Problems	6	2	-	-	-	-	-	-	-	-	8
Chemical Dependency	23	14	-	-	2	1	-	2	-	-	42
TOTAL	92	81	14	3	10	5	12	21	4	5	247
% of Total	37.3%	32.8%	5.7%	1.2%	4.0%	2.0%	4.9%	8.5%	1.6%	2.0%	100%

The maps are identified as:

Map 1: Community Based Residential Facilities - Minneapolis-St. Paul Metropolitan Area

Map 2: Minneapolis Community Based Residential Facilities

Map 3: Inset Map B (South Minneapolis)

Map 4: St. Paul Community Based Residential Facilities

Map 5: Inset Map A (Summit-University/Crocus Hill)

KEY TO MAP SYMBOLS

- ■ Adolescent Group Homes
- □ Child-caring Institution (Emotionally disturbed and other)
- ▲ Adult Community-based Corrections
- △ Juvenile Community-based Corrections
- ● Residence for Mentally Retarded Adults
- ○ Residence for Mentally Retarded Children
- ◐ Board and Care Home for Adults with Mental Health Problems
- ◐ Non-Board and Care Residence for Adults with Mental Health Problems
- ★ Halfway House, Three-quarterway House, or Non-Institutional Primary Treatment Center for Chemical Dependency

ST. PAUL PLANNING DISTRICTS

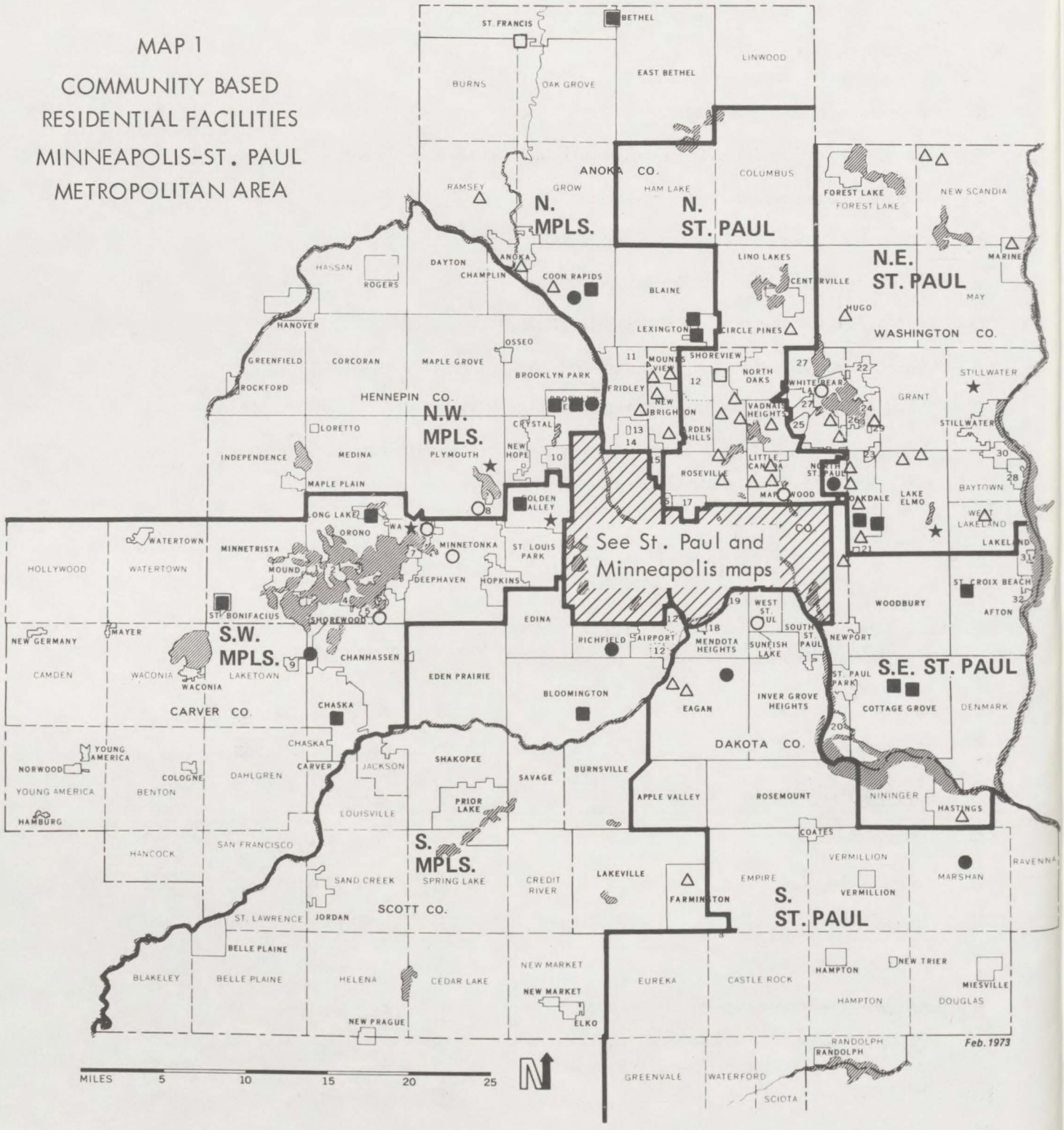
1. Battle Creek
2. Como Park
3. Crocus Hill
4. Daytons Bluff
5. Downtown
6. Hazel Park
7. Highland Park
8. Macalester-Groveland
9. Merriam Park
10. Midway
11. North End
12. Phalen Park
13. St. Anthony
14. Summit-University
15. Thomas-Dale
16. West Side
17. West Seventh Street

MINNEAPOLIS PLANNING DISTRICTS

1. Calhoun-Isles
2. Camden
3. Central
4. Longfellow
5. Near North
6. Nokomis
7. Northeast
8. Powderhorn
9. Southwest
10. University

MAP 1

COMMUNITY BASED RESIDENTIAL FACILITIES MINNEAPOLIS-ST. PAUL METROPOLITAN AREA



1 SPRING PARK	9 VICTORIA	17 FALCON HEIGHTS	25 GEM LAKE	ANOKA ——— County
2 ORONO	10 ROBBINSDALE	18 MENDOTA	26 BIRCHWOOD	GRANT - - - - Township
3 MINNETONKA BEACH	11 SPRING LAKE PARK	19 LILYDALE	27 WHITE BEAR	OSSEO ——— Municipality
4 TONKA BAY	12 U. S. GOVT.	20 GREY CLOUD	28 BAYPORT	
5 EXCELSIOR	13 HILLTOP	21 LANDFALL	29 WILLERNIE	
6 GREENWOOD	14 COLUMBIA HEIGHTS	22 DELLWOOD	30 OAK PARK HEIGHTS	
7 WOODLAND	15 ST. ANTHONY	23 PINE SPRINGS	31 LAKELAND SHORES	
8 MEDICINE LAKE	16 LAUDERDALE	24 MAHTOMEDI	32 ST. MARY'S POINT	

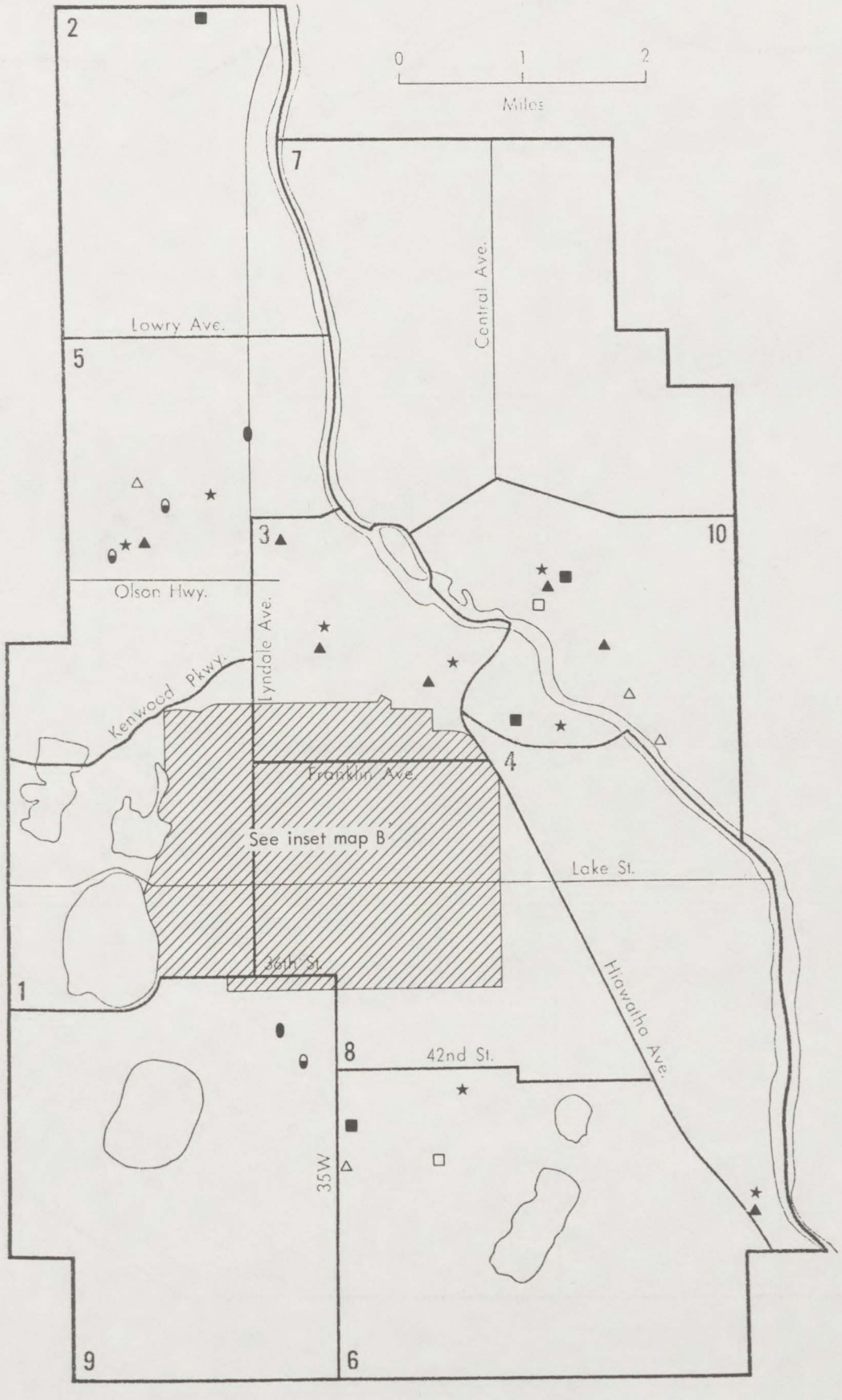
Metropolitan Area Suburban Sectors

Please see accompanying legend for symbol explanation.

Base map obtained from the Metropolitan Council.

MAP 2

MINNEAPOLIS COMMUNITY BASED RESIDENTIAL FACILITIES



[1] Planning District (See Planning District list for number identification.)

Please see accompanying legend for symbol explanation.

INSET MAP B (South Minneapolis)

Please see accompanying legend for symbol explanation.

INSET MAP B (South Minneapolis)

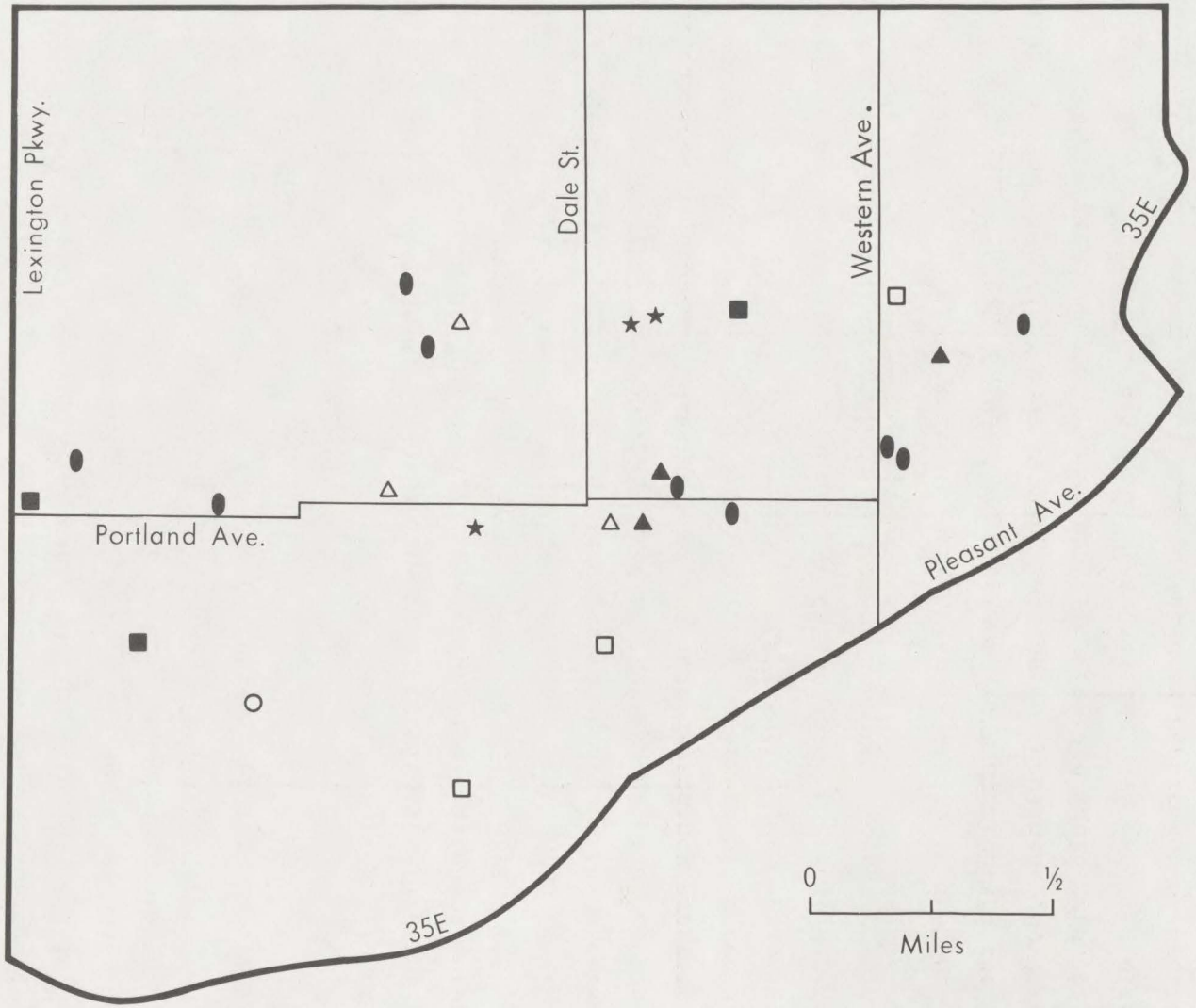
ST. PAUL COMMUNITY BASED RESIDENTIAL FACILITIES

1 Planning District (See Planning District list for number identification.)

Please see accompanying legend for symbol explanation.

MAP 5

INSET MAP A (Summit-University/Crocus Hill)



Please see accompanying legend for symbol explanation.

MAP 5

The most extensive development of community-based residential facilities has occurred during the last three years. Data about when program operations began was obtained for 83 percent (163) of 196 facilities, excluding the 51 juvenile community corrections group homes supported by Ramsey, Dakota, and Anoka Counties. Approximately 55% of the 163 facilities (95) began operations between 1974 and 1975. It is important to note that only 13 new facilities began operation in 1975, contrasted with 30 new programs in 1974. Moreover, one-third of the facilities that began operation in 1975 are attributable to one operator; Browndale Minnesota (Child-caring institution for emotionally-disturbed children).

Prior to 1972, the predominant types of community-based residential facilities were: 1) the board and care home, 2) institution-like residences serving mentally retarded children, 3) apartment-like residences serving mentally retarded adults, 4) a few group homes and child-caring institutions administered by private social service agencies, and 5) a few halfway houses for alcoholic persons adhering to an Alcoholics Anonymous treatment model. 1972 through 1975 witnessed the emergence of community-based corrections programs, a variety of chemical dependency programs serving the needs of special target groups, and a burgeoning in the number of adolescent group homes. This growth can be attributed to an availability of Federal funds, particularly in the areas of chemical dependency and corrections, and to foundation seed money support.

Continued public investment in these areas is likely to proceed more slowly as the merits of existing programs are evaluated and the availability of operating funds remains constant or declines. However, in the areas of group homes for both mentally retarded adults and children, not less than 15 operators, proposing 34 facilities have received either Metropolitan Health Board certificate-of-need or Department of Public Welfare provisional licensing review during the last year.[14]

At least three factors account for this development. First is the availability of low-interest insured loans through the Minnesota Housing Finance Agency for construction and remodeling of facilities to serve mentally retarded and physically handicapped persons. Second, the primary source of operating funds for these facilities is through Medicaid (Title XIX) a relatively secure source of reimbursement as compared with the "soft monies" supporting many of the other types of community-based residential facilities. Third, is State legislation superseding local zoning restrictions regarding group residences for mentally retarded and physically handicapped persons. In contrast to existing patterns, the geographical distribution of these proposed facilities centers on suburban locations.

During the period from 1972 to 1975, 29 facilities either closed or changed their location.[15] Among those facilities that closed (22), adolescent group homes (7) and juvenile community corrections facilities (7) predominate. Five chemical dependency facilities are included in those facilities that changed location and are still operating (7). 19 of these 29 facilities were located in the South Minneapolis (13) and Summit-University (6) areas. Certain homes once vacated remained in a "community-based residential facilities market" and were subsequently occupied by another residential program.[15]

The Minneapolis, St. Paul, and insert maps show that facility clustering patterns exist. It can be assumed that the proximal location of similar and dissimilar target groups may have both positive and negative client-related effects. For example, referring to the South Minneapolis insert, the area bounded by Pillsbury, Franklin, 26th Street and 35W has six chemical dependency halfway houses representing four different programs. Such a situation is potentially conducive to the sharing of professional services. As an example, one job counselor could be hired to serve client needs at all six facilities.[16]

Similarly, four residences for mentally retarded adults are located on the fringe of downtown Minneapolis. Location of a sheltered workshop at one of these sites, proximal to the other three residences, represents an additional example of a positive client-related locational effect. In such a situation, implications for shared transportation services are also evident.

In contrast, the hypothetical location of a home for mentally retarded adults in proximity to a juvenile community-corrections residence may be associated with negative client-related effects. A value judgement is implied in this statement. In such a situation, the potential for victimization of mentally retarded persons is assumed to be high. Further research is needed to confirm the validity of such assumptions and to investigate further what the positive and negative interactive effects are between similar and different types of facilities located near one another.

A related question also merits examination: what are the relative advantages and disadvantages for particular target groups of inner-city versus suburban residential facility locations? For example, in the case of chemical dependency halfway houses, should access to a lower-skilled job market, such as a day labor pool, be considered an important criterion in evaluating site selection? Or, by contrast, does "psychological distance" aid recovery, such that chemically dependent persons would rather seek care outside their immediate neighborhood or away from areas with high drug use?

As yet, these questions of the user-associated effects of facility location are unanswered. Meanwhile, as noted above, 95 new facilities began operations within the last 3 years. Associated with this development are neighborhood impact effects that for the most part have also gone unstudied. In the next section of this paper the phenomenon of community resistance to residential facilities is examined in depth. It is argued that an inherent structural conflict exists between the planning and

allocation of resources to community-based residential facilities at the county and regional level and local municipal attempts to control the development of these facilities through land use and zoning practices. As will be shown, the issues surrounding the location of community-based residential facilities not only reflect a conflict between levels of government in defining jurisdictional responsibilities, but raise much broader questions concerning equity in public investment and human valuation.

PART II : Analysis of Community Resistance Toward Community-Based Residential Facilities

Those who advocate establishing community-based programs for a particular target group are asking that a neighborhood absorb these persons into its social fabric. However, community-based residential facilities are generally regarded as "noxious facilities";[17] operations generally acknowledged by all as needed, but not necessarily desired by the residents at any potential site.

Examination of who decides when a public facility, e.g., community-based residential facility, is "noxious" and by what criteria, is central to addressing pragmatic policy issues concerned with the spatial distribution of these facilities. At least five different participants are involved in the process of establishing a community-based residential facility.[17] These participants are: 1) property owners adjacent or proximal to the proposed facility; 2) the "broader community" surrounding the facility; 3) various bureaucratic constituencies and elected officials impacting upon the operations of the facility; 4) the residential facility owner, operator, or program director; and 5) persons who will reside in the facility and/or advocacy groups organizing to establish facilities in behalf of these persons. It is important to bear in mind that the goals of these groups are distinctly different.

The primary social conflict revealed in the locational decision concerning group homes and halfway houses is between two values which have been referred to as "inherent equality" and "actual productive contribution".[18] "Inherent equality" assumes that all individuals have equal claims to entitled societal benefits regardless of the quantity or quality of their contribution. "Actual productive contribution" posits that individuals who produce more output--measured in some meaningful way--have a greater claim to societal benefits than those producing less.

Community-based residential facilities have as a goal the assimilation of both the physical structure and residents' social behavior into the everyday community life of the surrounding neighborhood. The "inherent equality" value is embodied in this goal of community integration.

However, the "actual productive contribution" value emerges in a variety of ways to provide the primary rationalization for neighborhood opposition to community-based residential facilities.

The following analysis focuses on the property owner and the "broader community", analyzing their perceptions of the negative impact of community-based residential facilities on the neighborhoods in which these facilities are situated. 46 community-based residential facility locational decisions were examined to determine the frequency of different arguments used by individuals and organized community groups to oppose the location of a facility in their neighborhood.

Before considering specific findings of this analysis, three general observations can be made. First, it appears that no type of community-based residential facility escapes opposition. Neighborhood residents do not positively discriminate between the persons who will occupy the home. For example, homes for both mentally retarded children and ex-offenders are as likely to encounter resistance although different arguments are invoked to buttress the opposition. While such resistance may differ in intensity, the intent is identical.

Secondly, if the facility can withstand a community's initial antagonisms, its survival, barring financial failure, is seemingly assured. In only one case examined was a conditional use permit revoked as a result of organized community opposition.[19] However, initial opposition from organized community groups can act to significantly influence the growth of group homes and halfway houses, i.e. the denial of conditional use permits. Proposed facilities ought not to ignore the impact of key informal community leaders, whether or not contact with these persons and groups is mandated by local zoning or licensing officials.

In cases reviewed where there was no opposition encountered, the residential operator had gained the support of key community organizations. Often the facility had been operating in the neighborhood for some time before application for the conditional use permit was made. In cases

where conditional use permits were granted and community opposition was evident, such opposition tended to be unorganized. These facilities were usually able to mobilize the support of professional groups which offset the effects of unorganized community opposition.

Finally, an interesting transition process is observed in examining what group homes and halfway houses were before residential facility use occurred. In many cases property use was already institutional in character, i.e., nursing home, board and care home, convent house, office building, or catered to transient occupants, i.e., rooming house, sorority or fraternity house. In this regard, the prior use of the residence would seem to indicate little or no chance of transition to single-family occupancy status. Rather, the only thing that is overtly changing in this land use transition is the characteristics of the occupants as perceived by a segment of neighboring residents.

A related issue that should be examined is the housing transition process that occurs when a community-based residential program ceases operations. As noted earlier, preliminary evidence in the Twin Cities indicates that many of these facilities remain in a "residential facilities housing market", i.e., new residential programs assume occupancy. Yet, homes do convert back to single-family and multiple-family use. Further investigation into the extent of this re-conversion and the characteristics of the new occupants appears warranted, particularly in light of the relationship between the growth and development of community-based residential facilities and issues of neighborhood succession.

Study Methodology

In examining locational decisions, 149 negative arguments were classified into four types:

1. Property values/economic: including a) "property devaluation" and b) "erosion of neighborhood tax base". (10 percent of responses) [15]
2. Land use compatibility: including a) "density of area"; b) "already too many in the area"; c) "availability of property elsewhere" (fair share argument); and d) "zoning incompatibility leading to flooding of other noxious facilities". (24 percent of responses) [36]

3. Neighborhood-quality of life compatibility: including a) "safety of children & elderly": b) "lifestyle of residents"; and c) "interference with quality of life", "housekeeping matters" (parking, traffic, property maintenance). (39 percent of responses) [59]

4. Program evaluation: including a) "lack of supervision of residents"; b) "not enough space for facility to operate effectively"; c) "qualifications of program staff"; and d) "financing of program". (27 percent of responses) [39]

If an argument is invoked more than once in the same case, it has been recorded only once. Data consist of planning memoranda and zoning decisions obtained from the planning and zoning departments of Minneapolis, St. Paul, and seven suburban Twin Cities municipalities.

The breakdown of cases examined by type of facility is:

Residences for chemically dependent persons	14
Adolescent group homes	8
Adult/juvenile community-based corrections	15
Residences for mentally retarded adults	5
Residences for mentally retarded children	3
Residences for adults with mental health problems	1
TOTAL	46

Appendix B provides a listing of those facilities included in the analysis. As noted, some of these facilities are no longer in operation, have changed locations, or are not found on the maps due to their "non-residential" character. For example, Minneapolis zoning authorities reviewed a mental health day activities center and a chemical dependency detoxification center under the zoning code's definition of a "halfway house". Such reviews illustrate the definitional difficulties with respect to community-based residential facilities discussed earlier. Additionally, if a facility had more than one location over time, both locational decisions may have been included in the analysis.

The range of facilities covered in terms of geographic distribution, facility type, and stage of operation (already operating, attempting to occupy an existing structure, or negotiating for the right to use a parcel of land to construct a new facility) lead the authors to believe

that findings are representative of arguments used to rationalize opposition to community-based residential facilities and have generalizability in this regard.

Community Resistance Based on Issues of Property Valuation

In the minds of property owners, for whom a primary goal may be to realize an increase in the worth of their investment, community-based residential facilities have come to be viewed as injurious to property values. This is the assumed effect of so-called "noxious facilities".[17] In this analysis, "property value/economics-based" arguments constitute only 10 percent (15) of the 149 negative responses recorded.

There is growing empirical evidence indicating that decreasing property values are not associated with the location of community-based residential facilities in a given neighborhood. A study conducted on the social impact of group homes in Green Bay, Wisconsin indicates that within a three-block radius of the one group home examined, there were no drastic increases or decreases in the percent of the houses sold each year after the program began operating. In the first block surrounding the facility, the proportion of homes sold each year dropped from 12.9 percent before the group home opened to 5.5% afterwards.[20]

The interpretation of this finding is limited in that the investigators fail to consider the demand side of the housing transaction process. While the presence of a group home may be associated with low housing turnover, this apparent neighborhood stability, which can in turn be associated with stable or increasing property values, may be more a function of an unwillingness of families to buy into the neighborhood. Potential sellers are then forced to remain where they are.

More recently, Dear has examined the relationship between the location of 12 satellite mental health facilities within the City of Philadelphia and the number of property transactions and the value of these transactions.[16] His findings suggest that while an increase in

sales activity occurred after the operations began in eight out of the twelve facilities studied, contrary to expectations, the value of the sales almost universally increased. As Dear notes:

> The anticipated noxious effect was not observed in this sample: there was even some evidence that a selective upgrading in neighborhood condition could be associated with the facility.[16]

Much of the observed increase in property values can doubtless be attributed to inflation. Yet, in risking generalization of these tentative findings to the Twin Cities case, significant questions on the limitations of such "impact analysis" must be raised.

Three methodological problems concerning property value impact analysis merit discussion. First, is the problem of selection of a suitable control against which to assess changes in the sample data.[16] For example, if one examines a single facility's impact in South Minneapolis, an appropriate control might be a neighborhood in Northeast Minneapolis where no residential services are to be found and which is relatively stable in its housing and demographic characteristics.

A second problem area is the issue of controlling for changes in the character of community land use while the selected impact variables are being examined. For example, how is the impact on property values in the South Minneapolis Whittier neighborhood to be evaluated in a situation where a group home and new neighborhood park are within a block of one another? Isn't property value over time more apt to be influenced by declines in condition of property rather then by the introduction of a new facility, thus making impact evaluation particularly difficult in transition neighborhoods and areas with an aging housing stock?

Third, and most important, is the problem of delimiting the impact area. In both the Philadelphia and Green Bay cases the impact of a <u>single</u> facility on a given neighborhood is examined. Neither study formally addresses how property value impact can be assessed

in the case of multiple facilities, that is, in neighborhoods where more than one residential facility is located.

For example, if we were to begin assessing property value impact in South Minneapolis, applying a six-block radius criterion around each facility, it would be possible to include as many as 14 facilities in this analysis. Moreover, we would be forced to weight the relative impact of different types of facilities in terms of potential "noxiousness", e.g., will a community corrections facility be assumed to have twice the negative impact on property values as a home for mentally retarded children when both are located in the same neighborhood?

In conducting such a study the following questions, among others, will need to be addressed:

1. Are the property impact effects in the case of multiple community-based facilities additive in the negative direction?
2. Is there an upper bound on the positive or neutral aspects of multiple-facility location which when marginally exceeded precipitates excessively high turnover rates and significant decreases in property values?
3. If group homes and halfway houses are perceived as investments by their operators who, primarily as property owners, are apt to upgrade these properties, is it not reasonable to posit an additive "neighborhood upgrading effect", representing the cumulative spill-over of individual property improvements?

These questions, as yet not systematically studied, lead to discussion of the second category of negative arguments invoked in opposition to community-based residential facilities: those that relate to "land use compatibility".

Community Resistance Based on Issues of Land Use Compatibility

Of the 149 negative responses recorded, 24 percent (36) are most closely aligned with this category. "Land use compatibility" arguments refer to community residents questioning the proposed land use, i.e.,

the community-based residential facility, in light of the existing land use in that community. As such, these rationales seek to avoid an evaluation of the programmatic merits of the facility but strive to focus on objective analysis of present and emerging community land use patterns, assessing how the proposed facilities fit with respect to these patterns.

In examining these responses, two forms of negative argument can be discriminated: one fitting the core city, the other the suburban municipality. In the former, the argument is couched in terms such as "density", "saturation", or "over-concentration"; of there being too many facilities already in the area. This rationale, in turn, leads opponents to invoke a "fair share" argument. For example, a North Minneapolis community group in voicing its opposition to an adolescent group home notes:

> The problem is metropolitan-wide and until the suburbs share the concern, we do not feel that the cities of Minneapolis and St. Paul should carry the entire burden. North Minneapolis has enough problems in maintaining our neighborhoods without taking on more. We sympathize with our South Minneapolis neighborhoods where the majority of these houses and homes are concentrated.[21]

In contrast, the suburban case more clearly reflects issues related to the general purposes of zoning--to regulate and control the use of land so as to insure the health, safety, morals, convenience and general welfare of the residents of the area in question. Often in the suburban case, the community-based residential facility is viewed as a precursor to the intrusion of more noxious forms of land use which may also require issuance of conditional or special use permits or the granting of zoning variances, e.g., double bungalows, townhouses, or apartment buildings in areas zoned single-family residential. Moreover, newly constructed community-based residential facilities in suburban areas have been perceived as potential "white elephants" should the program cease operation. For example, if three cottages, to be occupied by mentally retarded persons, are built on a large suburban lot and the program should close, what will become of those residences? How will they be able to enter the suburban housing market?

A key issue associated with these land use compatibility arguments is that of the definition of a family. As Klimberg notes:

> In its original sense, the phrase 'single family' was intended simply as a designation of a physical structure and not as a regulation on the type of dwelling occupancy.[22]

As such, issues of "land use compatibility" reflect a broader question--the right of equal access to housing by social groups who may or may not be thought to constitute a "family".

Babcock and Basselman remark:

> ...all residential zoning assumes one traditional mom-and-pop family in each dwelling unit. Where the system is challenged, whether by a haggle of hippies, a piety of priests, or an exemplar of ex-addicts, the system proves unadaptable.[23]

This historical rigidity in zoning practices in response to alternative living arrangements, including the community-based residential facility, can be traced to the "inherent equality--actual productive contribution" value conflict discussed above. In this regard, land use policies have been designed to afford fullest expression to the "actual productive contribution" value, perhaps at the expense of "inherent equality".

In voicing saturation or over-concentration arguments in opposition to group home or halfway house development, it is generally assumed that as the number of community-based residential facilities or the number of persons living in such facilities exceeds a certain percentage of total housing stock or neighborhood population, the neighborhood will assume the appearance of an institutional environment, discouraging the willingness of families to enter the community. This neighborhood succession phenomena has been referred to as "institutional tipping".[24] In the context of the racially changing neighborhood, Grodzins defines the "tipping-point concept" as:

> The process by which whites of the central cities leave areas of Negro in-migration.... The variations are numerous but the theme is universal. Some white residents will not accept Negroes as neighbors under any conditions ....others, sometimes willingly as a badge of liberality, sometimes with trepidation, will not mind if a relatively small number of Negroes move into the same neighborhood ....Once the proportion of non-whites exceeds the limits of the neighborhood's tolerance for inter-racial living (this is the 'tip point'), the whites move out.[25]

The phenomenon of "institutional tipping" has been publicly recognized both in Minneapolis and in St. Paul since as early as 1972. For example, in public hearings held in December 1973 to consider proposed revisions in St. Paul's zoning code, a community representative noted:

> ....these organizations are routinely locating in this area [Summit-University] far in excess of the needs of the community and in fact, this excess is resulting in changing the character of this area from what it presently is--a residential area--to an institutional area.[26]

From the perspective of community-based facility opponents, the fundamental issue is what kind of protection can be given the neighborhood such that its residential character can be retained? From a more conceptual point-of-view, an underlying dilemma is how to define the characteristics of a "normal residential neighborhood"?

Conceptually, the "normal residential neighborhood" can be associated with issues concerning single-family residential zoning briefly noted above. Unless the community-based residential facility was explicitly mentioned in local zoning ordinances or was considered a form of related land use, e.g., boarding home, health care institutions, et.al., its development was forestalled by a municipality's "definition of the family".

The most frequently used definition of family encountered in a survey of 30 Twin Cities municipalities is:

> an individual, or two or more persons, related by blood, marriage, or adoption living together, or a group of not more than 4 persons, who need not be related by blood, marriage, or adoption living together as a single housekeeping unit in a dwelling unit, exclusive of usual servants.

Thus, for example, under this definition of "family" local municipalities could limit group homes to two residents and a caretaking couple. The blood relation criterion tends to deny the "unrelated" access to suburban homes and the amenities associated with such locations.

It has been argued that "the more probable purpose of the single-family ordinance is to segregate families from non-conforming social units

believed to endanger traditional family survival on both moral and economic grounds."[22] It must be recognized, however, that urban neighborhoods, and to a somewhat lesser degree suburban areas, are undergoing a form of neighborhood or land use succession peculiar to the changing lifestyles and social policy issues of the 1970's, including deinstitutionalization. Thus, "institutional tipping", i.e., a neighborhood concentration of community-based residential facilities, needs to be recognized as a legitimate form of neighborhood succession in which the facility's residents and physical structure are attempting to unobtrusively blend into the surrounding community.

Community Resistance Based on Issues of Neighborhood/Quality of Life Compatibility

Of the 149 objections to community-based residential facilities, 39 percent (59) concern residents' beliefs or attitudes that location of community-based residential facilities in their neighborhood will unduly effect their "quality-of-life". The most important category of response is related to anxiety about who the new neighbors are and how their presence will affect the personal safety of neighborhood residents.

In a preliminary report submitted to the State Department of Public Welfare entitled "A Political Strategy to Combat Community Resistance to Residential Facilities for the Mentally Retarded in Minnesota" the consultants note:

> ....that no amount of educational programs before or presentations during the controversy about constitutional or human rights or about the benign nature of mentally retarded children and adults will significantly change the minds of those organized in opposition. [27]

In a survey conducted by the President's Committee on Mental Retardation, Ad Hoc Committee on Codes, Standards, and the Developmentally Disabled, a Pennsylvania group home operator remarked:

> ....we have found that zoning and building codes are not the most crucial issues obstructing the implementation of community-based residential programs and

> deinstitutionalization. Rather we have found.... that the single, most important problem confronting these programs centers around the attitudes and emotional opposition encountered from the community itself toward the mentally retarded [alcoholic, juvenile delinquent, et.al.][28]

It can be argued that reliance upon a traditional approach to community education to combat community resistance to residential facilities will result in failure. The notion conveyed by human services planners, who base their arguments on the "continuum of care" model is that the residents of community-based facilities are pretty much like everyone else: there is no sharp line dividing the sane from the insane, the chemically dependent from the drug-free 'straight', the juvenile delinquent from the 'teenager going through a phase' rather, a continuous range of human behavior exists.

The problem with this argument to combat community resistance is that it directly threatens a community's belief structure. Such problems have traditionally been dealt with within the private confines of the family or in state-supported institutions which isolate the deviant from the community. Although no empirical studies specific to the social psychological impact of the community-based residential facility are available, it is posited that as facilities begin to concentrate in a neighborhood, residents begin to doubt a set of stable beliefs, that is, that there is a difference between myself and "these persons"; isn't that why state hospitals, prisons, reformatories, et.al. exist?

A related point, alluded to earlier, is whether some types of facilities are viewed as less threatening than others. The findings of this study seem to indicate that while such a distinction regarding a particular facility may exist, overall, such a ranking is of little practical significance in areas where a high degree of "institutional use" already exists. A contrary opinion is offered by the Department of Public Welfare consultants mentioned above:

> Given general community attitudes, obviously, it is a sound policy for persons concerned about and pushing for community facilities and programs

> for the developmentally disabled to not associate their community-based program ideas and plans with those for the chemically dependent, the juvenile, the probationed ex-offender, etc. For while the society obviously treats the mentally retarded in a second-class manner and obviously has a whole range of ignorances, fears, and stereotypes regarding the developmentally disabled these are mild compared with attitudes about junkies, alcoholics, juvenile delinquents and criminals. [27]

Nevertheless, community-based residential facilities, regardless of type, are at least clearly associated geographically. To view facilities for mentally retarded persons as somehow "better than" facilities for chemically dependent persons is not borne out when one studies community reaction to these facilities. The question is no longer: "If one has to choose between Facility X whose residents are mentally retarded teenagers and Facility Y whose residents are male ex-offenders, which group is the least offensive?"

At this point in time, neither request is in all probability tolerable to the affected community. In the latter case, neighbors would argue that young children could not play in safety for fear of sexual molestation while in the former case it would be argued that elderly residents would be made "prisoners in their homes"! That the disability of mental retardation is not self-inflicted seems to make little difference in community attitudes.

Assuming the existence of such a social psychological reaction, a tack that ought to be considered by community educators or publicists is to clearly and openly discuss with community groups the rationales behind community-based programs and services as an alternative to institutional services. Such an approach ought to be developed so as to minimize residents personal fears -- "yes, there is a difference but ..."

Presently, neighborhoods appear to view deinstitutionalization policies as thrust upon them, with the source of authority for these

policies ill-defined. Such ambiguity leaves many of the locational and programmatic decisions regarding these facilities unjustified. While advocacy planning efforts have been initiated to assist potential and current facility operators to gain a foothold in a community,[29] little has been done to systematically work with community groups in a similar advocacy style.

Human services planners have imposed on various communities and neighborhoods a set of values--deinstitutionalization is a desirable goal and community-based residential facilities are an expeditious means to this end. However, little has apparently been done to work with affected citizens groups on an on-going basis to involve these persons, for example, in devising an equitable facilities distribution plan. It appears that planners have chosen to play, on a case-by-case basis, a broker role between the facility operator and a potentially hostile community. It seems that those who have been involved in these conflicts have yet to mobilize interested citizens on a broader level to confront neighborhood succession issues related to deinstitutionalization.

People equate deviation from behavioral norms with unpredictability.[30] Faced with the entry of one or more community-based residential facilities into a neighborhood, it may be that the community or segments thereof begin to question their own "normality"; the viability of established standards for social control.

Community residents may be caught in a clash of interests between their own desires to protect the integrity of what they define as "community standards" (the actual productive contribution value), and the desire to be responsive to more powerful segments of society, i.e., government and church, who state that deinstitutionalization is both necessary and desireable (the inherent equality value). The implications of this dissonance with respect to understanding planning issues related to urban social change requires further explanation.

Community Resistance Based On Issues of Program Evaluation

The last major category of objections to community-based residential facilities covers issues related to the operation of the facility. These objections are principally evaluative in nature, and focus on three related areas: 1) lack of perceived supervision and ambiguity about who is responsible for residents behavior; 2) uncertainty about the qualifications of the facility operator and/or residence care-takers; and 3) uncertainty about the financial status of the program, including the origin of capital expenditures and operating funds.

These objections are not grounded in issues of land use or "quality-of-life" compatibility as much as they represent the neighborhoods' curiosity about what a particular community-based residential facility desires to accomplish and how it has decided to achieve stated goals and objectives. As such these objections, which represent 27% (39) of the 149 negative arguments recorded, appear to reflect strong community interest in issues of residential services planning.

In considering the broader implications of these objections, it is critical to first discuss how the need for facilities is defined. As Dear notes:

> The catalyst for action within the public facility location context appears to be the articulation of need felt by some community groups.[16]

As Table 3 indicates the locus of responsibility for determining the need for most community-based residential facilities discussed in this paper is found at the County level.

TABLE 3

Type of Community-Based Residential Facility	Locus of Need Determination
Residences for mentally retarded children and adults	1) County/Area Mental Health and Mental Retardation Board 2) Metropolitan Health Board Section 1122, P.L. 92-603
Residences for persons with chemical dependency problems	1) County/Area Mental Health and Mental Retardation Board
Residences for persons with mental health problems	1) County/Area Mental Health and Mental Retardation Board
Adolescent group homes	1) County Welfare Departments 2) County Court Services
Community corrections residential programs--adult and juvenile	1) Governor's Commission on Crime Prevention and Control 2) Department of Corrections 3) County Community Corrections Advisory Board (Ramsey County)

While program need determination and subsequent funding support generally involve County-level negotiations, issues concerning location are not the direct concern of this level of government. Thus, as noted earlier, an inherent structural conflict between County control over the allocation of resources and local municipal land use control appears evident.

It must be recognized, however, that while need in a global sense is determined at the County, multi-County, and State levels, agency planners are primarily responding to highly localized requests from "special interest" groups for specific types of community-based residential programming activities, e.g., a group home to serve adolescent girls from the Near Northside (Model Cities, et.al.), a residence for Native American chemically dependent women, a group home for severely multi-handicapped retarded children and so on.

As such, the task of objectively determining the need for a given number of residential slots is formidable. Difficulties in identifying the extent of relevant target populations has been evidenced in the areas of community corrections[10], mental retardation[31], chemical dependency[32], and mental health[7]. While the "continuum of care", "normalization", and "transition" principles have become established human services planning concepts, a critical planning problem lies not only in defining the dimensions of the target populations (how many persons with certain socio-demographic characteristics having what extent of social disability) but in designing effective and efficient residential programs carefully matched with identifiable client needs.

For example, in a study of juvenile offender residential treatment alternatives available to Hennepin County Court Services the author notes:

> Services to clients range from those facilities which deal exclusively with chemical depedency problems to facilities that work with hard core delinquents for whom other treatment programs have had no success. The absence of any central clearing house of information makes it extremely difficult to match up the appropriate facility with the needs of the client. [33]

The character of the placement process would appear to be directly related to the ability of the residential facility to operate efficiently, i.e., at optimal capacity levels. A key area for further study is examination of the residential placement decision. Juvenile residential placements appear especially suited for such study. This is an area where a number of diverse programs exist, often making it difficult for case workers and probation/parole officers to optimally match clients with programs. For the most part undocumented, inappropriate client placement must be considered a significant hidden cost in establishing certain kinds of community-based residential facilities.

Questions about what occurs while a person is in residence are related to placement issues. In its evaluation of residential community corrections programs, the Governor's Commission on Crime Prevention and Control notes:

> Failure to rely on community agencies may result in discontinuity of treatment after residence. Greater use of community agencies would improve continuity of treatment for problems, such as drug dependency and alcoholism, which cannot be resolved during relatively short residential stays.[10]

In planning community-based residential facilities, increased attention needs to be given to the importance of "inter-system linkages", i.e., client flows between the residential facility and relevant client support services in the community. It can be argued that the more explicit and stronger these linkages are, the less chance that the residential program will engender negative spillover effects.

The Cost/Efficiency Question

In the study of the residential community corrections programs done for the Governor's Commission on Crime Prevention and Control, evaluators noted that during the study period, approximately one-third of community corrections halfway house residents had an acknowledged chemical depedency problem.[10] If, after leaving the halfway house, many of these persons subsequently enter the chemical depedency services system, it can be argued that the true costs of the community corrections facility are being underestimated.

Consideration in planning of the essential linkages between the community-based facility and relevant support services is crucially important in considering whether policies of deinstitutionalization are likely to result in cost reduction or merely cost redistribution. For example, in the case of mentally retarded adults and children, the efficacy of community-based residential facilities seems inextricably linked to the availability and accessibility of day activity center and sheltered workshop opportunities.

In a planning study projecting the need for work activity and sheltered employment opportunities through 1979 for persons residing in Ramsey County who are mentally retarded, the consultants note:

> The five public school systems in Ramsey County anticipate that 134 persons in 1975 and 1,081 by 1979 will move from the schools to sheltered employment or work activity. The movement of patients from state institutions to community-based facilities suggests another demand for sheltered employment or work activity: thirty such persons in 1975 and up to 283 by 1979.... Projecting the demand for 1979 sheltered employment by persons who are retarded rising from 188 in 1974 to 1,166 will suggest an increase from $681,192.83 spent in 1974 to $9,190,564.35 (13 percent inflation) or $11,273,634.24 (19 percent inflation).[31]

From such a perspective it is apparent that a mere comparison of community residential per diem rates with institutional rates, does little to take into account the costs associated with providing requisite support services that are critical to the success of community re-integration efforts.

Similar concerns surround development of planning strategies given the probable closing of state institutions. Currently, many persons who have been in mental hospitals reside in board and care homes in the community. Lamb and Goertzel describe such a living situation as:

> ....for the most part so structured that they maximize the state-hospital like atmosphere. The boarding home operator usually needs or wants a group of quiet, docile, "good" patients. The monetary reward system of the boarding home encourages this, for the operator is being paid by the head, rather than being rewarded for rehabilitation efforts for her "guests". [34]

Generally, it would appear that the board and care home system has not been adequately linked to the available array of community mental health services. While hard evidence is not available, residence in a board and care home does not seem to serve as an effective springboard to personal growth and eventual autonomy for the ex-mental patient, particularly if strong inter-system linkages are absent.

Community resistance to halfway houses and group homes should be considered as Area Mental Health Boards plan alternative living environments for persons with mental health problems. In contrast to a halfway house approach, the Department of Mental Health of the State of Missouri [35] and the staff of Boston State Hospital, Boston, Massachusetts[36] have developed a community-based treatment modality based on ex-patients renting one apartment of a tri-plex or a four-plex. While utilizing the landlord as a "resident supervisor", the allocation of resources in such a program is concentrated on staffing "community home teams" who visit each apartment regularly and are available to landlords, residents, and residents' families around the clock.

Cost figures for the Massachusetts program reveal that to establish a conventional halfway house in 1972 required approximately a $40,000--$80,000 initial funding commitment, and $3,000--$4,000 annual maintenance costs per patient.[36] By contrast, the "landlord-supervised cooperative apartment" required no initial funding, and in 1973 had an annual maintenance cost of $2,183 per patient; this sum combined $1,788 from Massachusetts Department of Public Welfare SSI and $395 attributable to state hospital staff and space costs.

Requiring the active participation of landlords, both programs appear to have effectively obviated community resistance. In Boston, four persons generally reside in an apartment; the landlord's monthly rental income ranging between $320 and $400. In addition to this financial incentive, Chien and Coe note:

> Helping the patient to relearn community skills and daily household chores on the landlord's own premises is both rehabilitative for the patient and practical for the landlord. Thus, this program attracts landlords who often have difficulty with regular tenants who are sometimes delinquent in their responsibilities.[36]

Moreover, because all apartments have access to the services of the community home team, observers in the St. Louis case note:

> The program is thus a factor in the promotion of neighborhood stability, both economically and in terms of social services. It introduces the concept of caretaking services to neighborhoods whose regular residents may be [as] marginal in their style of life as the ex-patients.[35]

The above discussion has focused on difficulties related to allocating resources to community-based residential facilities on the basis of needs assessment. Alternatively, the present "normalization services system" represents a situation in which significant competition can be assumed to exist between programs for residents. It is argued below that the optimal allocation of resources for community-based residential facilities might be better left to the market as a reflection of client demand, rather than to professional definitions of need.

As reflected in utilization patterns, it is apparent that demand for community-based residential facilities is regional in scope. While the authors were unable to conduct a comprehensive client-origin study,[37] it is clear that the service area of an individual residential facility often exceeds a single County or municipal boundary. Host-county purchase-of-service agreements, under the Department of Public Welfare administered Title XX, provide significant fiscal support to such inter-county placements.[38] To what extent the small scale of many facilities allows them to confine

client pools to a specific geographical area, or whether the specialized nature of the services provided coupled with a program's reputation results in facilities drawing clients from a widespread area, is a question requiring further investigation.

With the exception of community corrections programs funded through the Governor's Commission, utilization of other types of community-based residential facilities appears high. Minnesota Department of Public Welfare statistics for the period January-March 1975 indicate occupancy rates of 85.6 percent for 37 metropolitan based adolescent group homes reporting and 95.8 percent for 22 facilities serving adults and children who are mentally retarded. [39]

It is revealing to note the reasons given by the Governor's Commission to explain the low occupancy rates in its supported projects:

> The low occupancy rates can be attributed to three major factors. First, by their very nature, community corrections projects are not closely affiliated with the criminal justice system and must independently recruit clientele. Second, some projects do not serve a large enough population to keep the project filled. Third, the occupancy rate of halfway houses is depedent, almost entirely, upon the policies of the Minnesota Correction Authority.[10]

The above not only reflects the importance of a program's inter-system linkages in contributing to optimal occupancy levels, but brings into focus a critical question regarding future planning of residential facilities--should the determination of what residential needs are worth meeting and at what cost be worked out in a "residential services marketplace" through an inter-play of supply and demand?

The present "normalization services system" reflects a multiplicity of service delivery channels in the same geographic area and for similar services. For example, low occupancy rates for the community corrections programs can be viewed as a function of proving a poor competitor against alternative means of serving similar client groups, e.g., adolescent group homes, certain chemical depedency programs, county-sponsored community correction programs, and non-residential community corrections programs. As the community corrections evaluators note, those who had

the ability to refer clients when confronted with an array of programs from which to select chose not to refer to community correction programs sufficient numbers of persons to insure optimal program occupancy levels.

The impending development over the next two years of 30 to 35 group homes for mentally retarded persons represents another example of the effect of market demand on the growth of community-based residential facilities. Often, in response to the concerted efforts of client advocacy groups and parents of mentally retarded persons, such homes are established to meet highly specific and complex client needs.

The State of Minnesota allows licensed residential facilities to be operated for profit. Such a situation begs a question requiring further investigation: Are there any differences between not-for-profit and for-profit community-based residential facilities within a given facility type, particularly with respect to the characteristics of the persons served or the treatment modalities employed?

In a competitive planning environment, what is inefficient or ineffective will cease to be supported.[40] This does not mean, however, that the search for workable models of community-based residential services should cease. As the Governor's Commission on Crime Prevention and Control in putting forth its recommendation to establish a funding moratorium on new community corrections programs carefully notes:

> ....The sole exception to this moratorium should be those projects which test, under strict experimental controls, specific programmatic models....<u>The evidence presented here does not mean that residential community corrections cannot be a viable concept. It is simply too early to tell. But the data do raise disturbing questions which must be answered before continuing unabated funding of these programs</u>.[10]

The Control Setting

To prevent local ordinances from prohibiting community-based residential facilities from locating in residential zones, the State of Minnesota enacted into law on April 30, 1975, legislation that would supersede local zoning ordinances. This legislation provides that community-based residential facilities for six or fewer mentally retarded and physically handicapped persons be allowed in single family residential zones without conditional use or special use permits, unless the proposed facility is within 300 feet of an existing licensed community residential facility. [41]

It would seem that this 300 foot "acceptable distance" provision would tend to discriminate against locating community-based residential facilities for the mentally retarded and physically handicapped in "institutionally tipped" neighborhoods. Recalling the map of facilities located in South Minneapolis, this 300 foot criterion may be too low to have a practically significant effect on controlling the distribution of these facilities at the neighborhood level, but may prove a deterrant for locating a group home for mentally retarded or physically handicapped persons on a particular block.

For example, such homes would not in all probability be allowed on a block that already has a chemical dependency halfway house (licensed under DPW Rule #35) or an adolescent group home (Licensed under DPW Rule #8). Recalling earlier discussion of the potential user-associated effects of different types of group homes in close proximity to one another, such a distributional effect may be desirable. This holds true if one believes minimizing the potential (though unconfirmed) victimization of a mentally retarded or physically handicapped person ought to be considered a legitimate locational criterion in choosing a central city site for such a community-based residential facility.

Moreover, under this statute, community-based residential facilities for 7 to 16 mentally retarded or physically handicapped persons are

considered a permitted multi-family residential use of property for purposes of zoning. The local zoning authority may require a conditional use or special use permit in order to assure proper maintenance and operation of a facility provided that the conditions imposed on the homes are no more restrictive than those imposed on other conditional or special uses on residential property in the same zone.

Of long-range significance to the development of group homes and halfway houses is a provision of the law that is in essence a first attempt to plan for the equitable distribution of community-based residential facilities. Imbedding an allocative function within the licensing process Section 1 Subdivision (2) notes:

> In determining whether a license shall be issued pursuant to this subdivision, the commissioner of public welfare shall specifically consider the population, size, land use plan, availability of community services and the number and size of existing public and private community residential facilities in the town, municipality or county in which an applicant seeks to operate a residence. [41]

Regulations have yet to be promulgated as to how the Commissioner of Public Welfare is to make this determination.

Examination of four municipal zoning ordinances which explictly address control over the location of community-based residential facilities provides insight into how distributional control could be performed. The intent of this review is to recognize those features in these zoning regulations which might be incorporated into model zoning ordinances promulgated by local municipalities and which ought to be reflected in extending the provisions of the State enabling legislation to cover all types of community-based residential facilities. Such a proposal, HF No 354, was passed by the Minnesota House of Representatives on May 2, 1975 and has yet to receive Senate action.

In developing model zoning legislation with respect to the community-based residential facility, four issues need to be addressed--how are these

facilities to be defined, what will be the extent of their permitted versus conditional use, how is overconcentration to be controlled, and in what ways can a community integration or citizen participation requirement be made a provision of the zoning ordinance?

Table 4 presents the manner in which Golden Valley[42], Eden Prairie[43], Minneapolis[44], and St. Paul[45] have addressed these issues.

TABLE 4: Local Zoning Ordinances Pertaining to Community-Based Residential Facilities

	Definition of Community-Based Residential Facility	Extent to Which Facilities are Permitted on Conditional Use	Controls on Overconcentration	Citizen Participation/Community Integration Requirements
lden Valley[28]	Covers adolescent group homes only (licensed under DPW Rule #8)	Permitted use in all residential districts provided home has four children or less including children of house staff. Otherwise public hearing is required.	No group home shall be allowed within one mile of another group home.	Facility operator responsible for forming an advisory committee before program commences operation. This advisory committee shall have among its members: --a representative of the facility --2 reps. from the neighborhood surrounding facility --member Golden Valley Human Rights Commission --member of the Village Police Department --member of local school district.
en Prairie[29]	A) Supervised Residential Programs: Facilities exclusively for individuals with associated disabilities of mental retardation, mental illness, physical handicaps, and alternative living arrangements for the elderly. B) Social Rehabilitation Programs: For chemical dependency, juvenile delinquency, runaway children or young adults, women's emergency residential program, single parent residential program.	Both A) and B) are permitted use in all residential zones provided there are not more than six unrelated adults or children in the home. No mechanism to handle requests of greater than six persons, i.e., not permitted.	A) Residential facilities should not exceed 3% of total dwelling units in the neighborhood in which they are situated. B) Proposed facilities are to be located not closer than 500 feet from another facility.	An affirmative plan for community involvement is a requirement which includes but is not limited to: --Advisory Board: including professionals, home residents, parents of home residents, and concerned community members. --Community Based Services Board: purpose is to assist all community-based residential programs by providing a conduit for resolving and integrating the homes into the community. Such a board shall be created by City Council.
nneapolis[30]	A) Group Home: A building housing a program of special foster care to not more than (10) children including counselor, manager, or house parent's children. B) Halfway House: A building housing a program of resocialization to assist persons in making the transition from treatment to responsible community living. Includes programs of Governor's Crime Commission. C) Residential Treatment Center: A building housing a program of social and behavioral rehabilitation for individuals diverted from institutional incarceration or for individuals enrolling on a voluntary basis.	Community-based residential facilities are a conditional use in all residential and B1/B2 zoning districts. Homes for mentally retarded not explicitly covered.	No explicit criteria for controlling overconcentration.	An applicant for a conditional use permit for a group home or halfway house is expected to have considerable communication with neighborhood or community councils and with residents of the surrounding neighborhood, before the formal public hearing on the request. Permits for halfway houses are reviewed every six months; permits for group homes are not reviewed. No formalized mechanism required for ongoing community involvement.
. Paul[31]	A) Community Residential Facility: State licensed group homes serving mentally retarded or physically handicapped persons. B) Residential Group Home: A building or structure where persons reside for purposes of rehabilitation treatment or special care, and which is not a community residential facility... Such persons may be orphaned, suffer chemical or emotional impairment, or suffer social maladjustment or dependency.	1) R-1/R-4 one-family residential districts: --permitted use: A) - 6 persons or less --conditional use: B) - no more than 10 persons in excess of definition of family 2) RT-1 two-family residential districts: --permitted use: same as above --conditional use: same as above --conditional use: community residential facilities of not more than 16 residents 3) Multiple-family zones: 2) applies.	For A) a minimum of 1,320 feet will be required between zoning lots used for residential group home facilities. For B) a minimum distance of 300 feet will be required between zoning lots used for community residential facilities.	No explicit community involvement requirement for facility.

In terms of defining this type of land use, Eden Prairie's typology of community-based residential facilities appears to be the most comprehensive and least ambiguous. Under its previous zoning code, the City of St. Paul had attempted to define the zoning of community-based residential facilities in terms of other forms of controlled land use, i.e., "boarding homes" and "facilities for the care of sick persons".[46] Such an approach led 17 community-based residential facilities to be identified as illegal in the zoning districts they occupied, 25 were identified as being in allowable zoning districts but without requisite special use permits, and only 13 out of 55 facilities surveyed were found to be properly zoned in an allowable district and having a special use permit, if required.[47]

As is noted in Table 4 , these municipalities have made explicit that the community-based residential facility is a distinct form of land use, qualitatively different from institutional types of land use with which it may be related.

In considering the question of whether residential facilities ought to be permitted uses in all residential districts, or be restricted through conditional or special use permits, Eden Prairie and St. Paul have brought their ordinances in closest conformity with State legislation. If community-based residential facilities are a conditional use, then each case must be reviewed by the local planning commission and generally a public hearing must be held. Operators of homes claim that being a conditional use places on them the difficult burden of education and is discriminatory to prospective residents. Proponents of the conditional use permit claim that the community integration goals of the homes will not be achieved if homes are placed in neighborhoods which are opposed to such residents.[48]

The Minneapolis case illustrates that allowing community-based residential facilities in all residential districts and requiring a conditional use permit does not seem to result in significant dispersion

of facilities throughout the city. The lack of objective criteria by which locational impact of the facility can be judged has led, in part, to the overconcentration pattern observed in South Minneapolis and to the politicization of these public facility locational decisions. Moreover, it is not clear that the costs involved in this review process are positively associated with an outcome of increased community integration.

As noted in Table 4, in Minneapolis "halfway houses" and not "group homes" are required to have their conditional use permits reviewed every six months by the City Planning Commission and City Council in the same manner as the original application was processed. It is possible that this six-month review for halfway houses represents a form of undue harrassment. As Smith, writing in the Cornell Law Review, notes:

> If a nuisance situation does arise, vigorous enforcement of carefully circumscribed general police power ordinances constitutes a far more potent control mechanism than does [single-family] zoning. The practical difficulty of applying land use regulations to prevent the evil is found in the seeming inability to define the offending groups precisely enough so as not to include innocuous groups within the prohibition.[49]

There has been only one conditional use permit revocation in approximately 90 conditional use permit reviews. It is doubtful whether this form of reactive case-by-case regulation can be considered an effective means for redistributive facility planning. Rather, the only tangible result of this policy has been to somewhat limit the quantity of facilities locating in Minneapolis.

In addressing the issue of control of overconcentration, the City of St. Paul's 1,320 feet or one-quarter mile "acceptable distance criterion" would appear most appropriate for inclusion in a model zoning ordinance. This acceptable distance criterion can be coupled with a measure of "institutional density" as in Eden Prairie, i.e., residential facilities should not exceed 3% of the total dwelling units in the neighborhood in which they are situated.

The primary difficulty in developing a neighborhood-level institutional density measure refers to its implementational feasibility. Assuming a quarter-mile radius restriction and the combined number of persons to be served by both the proposed and existing facilities located within this radius set at less than ten percent of the total number of persons residing within the radius, it is readily apparent that for each proposed facility a different population base would have to be computed. While this might not be particularly difficult in communities with few facilities, situations such as in South Minneapolis or Summit-University would make such calculations burdensome. In all likelihood, radii would not be coterminous with census tracts, and calculations would have to be performed on a block by block basis.

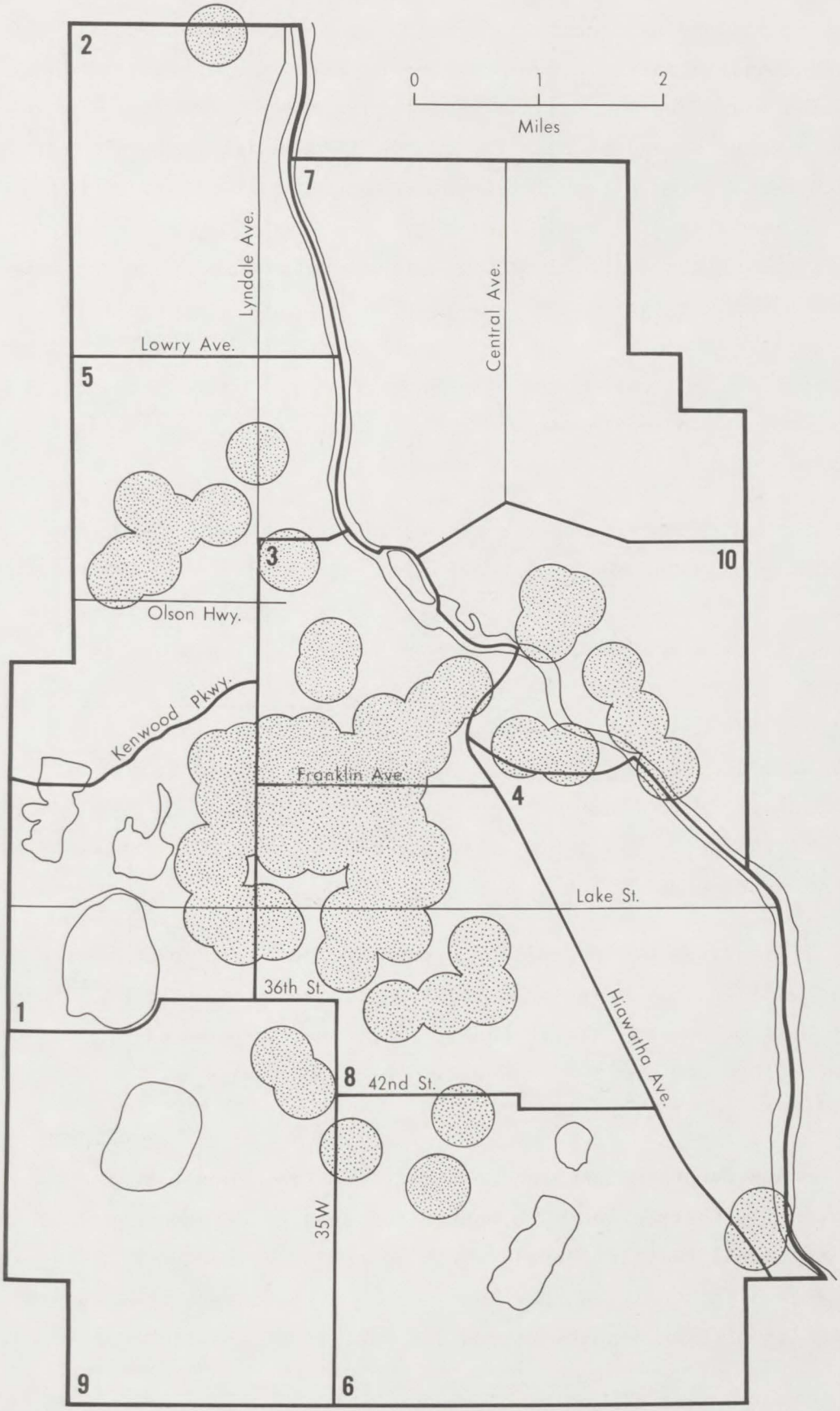
In Maps 6 and 7, "acceptable distance zones" have been constructed for Minneapolis and St. Paul by drawing circles of one-quarter mile radius around those facilities asterisked in Appendix A. These facilities consist primarily of licensed and potentially licensable operations under DPW Rules #5, #8,#34,#35, and #36, in addition to community corrections and other residential programs with a capacity for 5 or more residents. As these maps illustrate, judicious application solely of the quarter-mile criterion would preclude further clustering patterns. Community-based residential facilities would be forced to disperse into areas that are primarily zoned R-1 and R-2.

Implications of controlling overconcentration through this approach are significant for planning purposes. Utilizing acceptable distance zones will discourage single facility operators and encourage residential operators who can realize economies of scale through the administration of multiple facilities.

A complementary approach to density control, would be to couple the quarter-mile restriction with control of square footage requirements at the individual facility level. Such an approach, would weight residential districts differently to take into account the differential absorption capacities of high density versus low density residential districts. The

MAP 6

MINNEAPOLIS ACCEPTABLE DISTANCE ZONE MAP

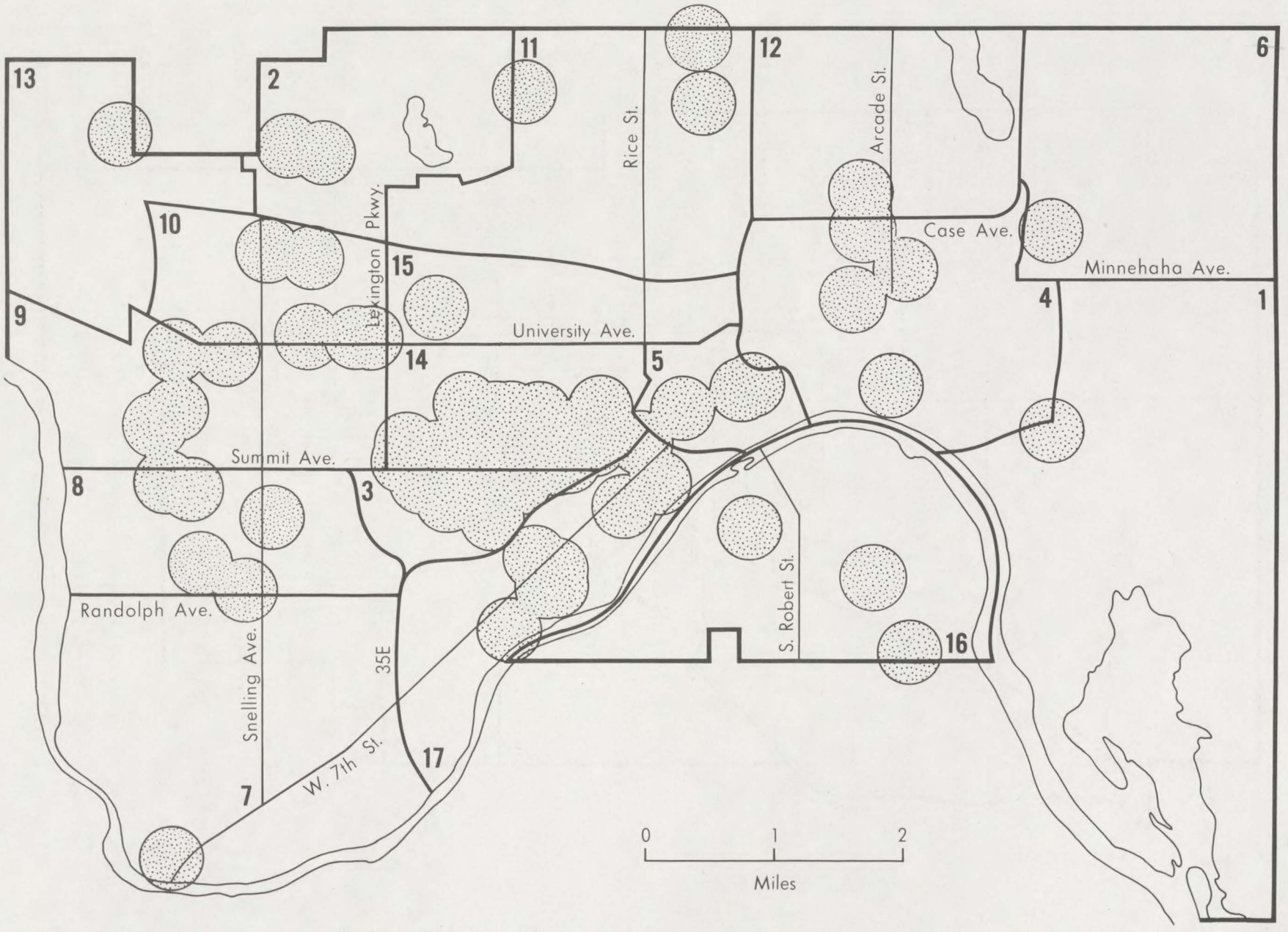


1 Planning District (See Planning District list for number identification.)

Area within one-quarter mile of group facility

MAP 7

ST. PAUL ACCEPTABLE DISTANCE ZONE MAP



1 Planning District (See Planning District list for number identification.)

Area within one-quarter mile of group facility

acceptable distance criterion would thus control residential density at the neighborhood level, while reasonable square footage requirements would assure adjacent and proximal neighbors that the facility does not represent an instance of overcrowding.

However, care must be taken in constructing square footage requirements. In the initial proposal to revise the St. Paul zoning code, the following requirement was put forth:

> For each group home resident allowed in (1) above, there shall be provided to the minimum lot size an additional lot area of 2700 square feet in a R-1 district, 2100 square feet in a R-2 district, 1700 square feet in a R-3 district, and 1400 square feet in a R-4 district.[50]

Under this proposal, with a minimum lot size of 5000 square feet for an R-4 district, if a group home operator desired to conduct a program on a lot of 7000 square feet, he could only have 1 1/2 residents. Primarily as a result of advocacy efforts of the St. Paul Association for Retarded Citizens, this criterion was eliminated. This is not to say that such an approach to controlling for institutional density is unworkable. In Table 5 the recommendations of the American Society for Planning Officials for density controls for "individual group care facilities" are reproduced.

TABLE 5 EXAMPLE OF DENSITY CONTROLS FOR INDIVIDUAL GROUP CARE FACILITIES FOR CITY "X"

Warning: The figures contained in this table should not be construed as model figures. They are used to illustrate the appropriate magnitude and approach to density regulation for family and group care facilities. Circumstances of each municipality--housing codes, fire codes, etc.--will of course demand figures appropriate to these circumstances.

Type of Residential District	Minimum Lot Area in Square Feet	Minimum lot area in square feet required for group care facility*	Minimum floor area in square feet required for group care facility*
Single family	10,000	10,000 for first 18 residents 1,200 for each add'l. resident	2,700 for first 18 residents 110 for each additional resident
Single Family	7,000	7,000 for first 15 residents 1,100 for each add'l. resident	2,300 for first 15 residents 110 for each additional resident
Single Family	5,000	5,000 for first 12 residents 1,000 for each add'l. resident	2,000 for first 12 residents 110 for each additional resident
Multifamily (low density)	5,000	5,000 for first 12 residents 1,000 for each add'l. resident	2,000 for first 12 residents 110 for each additional resident
Multifamily (medium density)	5,000	5,000 for first 15 residents 700 for each add'l. resident	2,300 for first 15 residents 110 for each additional resident
Multifamily (high density)	5,000	5,000 for first 20 residents 500 for each add'l. resident	3,000 for first 20 residents 110 for each additional resident

* Figures are given in such a form that more than 20 persons may reside in a group care facility even though the U.S. Law Enforcement Assistance Administration recommends that the "resident capacity...must not exceed 20 clients". This is done so that the one exception to this rule--the so-called "therapeutic community setting", where there may be up to 30 or 60 residents--may exist. These settings refer to facilities oriented toward the alleviation of drug abuse, alcohol, or psychiatric problems. Occasionally the orientation of the program of this type of facility will allow it effectively to handle more than 20 residents. Such facilities, however, are quite rare and are usually established on large estates or in YMCA-type facilities.

[Table reproduced from: Lauber, D. and Bangs, F.S. "Zoning for Family and Group Care Facilities," American Society of Planning Officials Planning Advisory Service Report #300, Chicago, Illinois, 1974]

As regards specific citizen involvement/community integration requirements, Eden Prairie's concept of a Community-Based Services Board is innovative in its intent. In contrast to Golden Valley or Minneapolis, the burden is not placed on the operator to integrate his facility into the community. Rather, a shared responsibility for community integration of the facility is acknowledged. Moreover, while an individual facility has the option of establishing a neighborhood-based advisory board, it is nevertheless accountable to a city-wide body responsible for resolving issues regarding the care and treatment of socially disabled persons in the community.

Given the City of Minneapolis' current citizen involvement requirement for community-based residential facilities, such an approach represents an alternative worthy of exploration. In Minneapolis, emphasis is focused on the initial encounter with the neighborhood generally leaving subsequent community integration efforts to the discretion of the operator.

It is argued that gaining initial public acceptance does not constitute genuine community integration. In Minneapolis, while certain organized community groups have been granted de facto review and comment powers over all new applications for group homes and halfway houses as well as renewals of their conditional use permits, such veto powers can be viewed as basically non-facilitative of genuine community integration. This procedure does not appear to provide a formal mechanism for on-going dialogue between the facilities and the neighborhood concerning substantive issues of program operation. In contrast to the potential of a city-wide Community-Based Services Board, individual community organizations are placed in a position of "gate-keeper" without any objectively defined criteria on which to base their "barrier-to-entry" decisions.

Lack of clear-cut planning criteria for the equitable distribution of community-based residential facilities and difficulty in identifying who is responsible for such planning has led at various times to calls

for a "moratorium" on all new facilities in both St. Paul and Minneapolis.[51] In light of State policies and statutes encouraging deinstitutionalization, the legality of any local moratorium would be questionable. In Hepper vs. Town of Hillsdale, the New York State Court ruled:

> ....It can be safely said that the state has an abiding interest in the control and rehabilitation of addicts and in furtherance of that interest has legislated an extensive and comprehensive program including the use of qualified private facilities ....The Town of Hillsdale takes the position that drug and narcotic addiction is a social evil and its ordinance is salutory in that it combats such evil. However, little argument is required after a comprehensive and sympathetic reading of the ordinance, to conclude that the thrust and import of the act is not to regulate or control a drug rehabilitation center in the Town but to prohibit such centers from operating. The purpose of the ordinance is obviously inconsistent with the organic law of the state and, therefore, is unreasonable, arbitrary, and oppressive to a valid state purpose ....such legislation cannot be so oppressive in nature so as to remove the Town from participation in an overall state program.[52]

In striking down a local ordinance expressly prohibiting the establishment of a chemical dependency halfway house, the Court, however, offered no guidance to the local municipality on how it could act to control the distribution of these facilities. By implication, if state policies are encouraging deinstitutionalization, then the state should assume a more visible and active planning role in the development of these facilities.

A survey of some 25 Twin Cities municipalities in addition to those discussed above, indicates general uncertainty as to how a request to locate a community-based residential facility would be handled. Various options include treating it similar to boarding homes, rest homes, et.al., leaving it undefined so as to facilitate flexibility in the location decision, or amending the current zoning ordinance to explicitly cover this form of land use through the conditional or special use permit mechanism.

Conclusions and Recommendations

This paper has focused on analysis of issues concerning the growth and development of community-based residential facilities in the Twin Cities metropolitan area. From the perspective of critically examining various types of community resistance to these facilities, certain conclusions for future policy action and research have been reached.

First, while property devaluation is often mentioned as a negative impact of community-based residential facilities, no hard evidence exists that this is the case in the Twin Cities. Empirical studies in Green Bay, Wisconsin,[20] Philadelphia,[16] and other cities[3] seem to indicate that the reverse situation might very well exist as residential operators tend to upgrade property in neighborhoods that are in the process of undergoing significant transition. The relationship between housing turnover rate, property valuation, and the presence of community-based residential facilities is not yet clear.

Difficulties in measuring the property impact of community-based residential facilities were noted, particularly in the situation where many facilities are clustered in a small geographical area. Potential methodological problems aside, it is recommended that:

> A study be conducted to answer the question: Does a clustering of community-based residential facilities have a negative impact on surrounding property values?

The outcome of such a study would be to provide empirical evidence that a negative impact on property values is indeed associated with facility clustering or that this contention is illegitimate. Findings in either direction, would hopefully lay this issue to rest allowing planners, elected officials, and community groups to either move for more stringent control policies or to address more significant planning issues regarding these services.

Second, issues concerning land use compatibility have begun to be resolved through the passage of State legislation. With the probable

passage of legislation that will extend this statute to cover all types of community-based residential facilities, licensed by the Department of Public Welfare i.e., HF 354, it is recommended that:

1. Local municipalities move to explicitly define this type of land use in their local zoning ordinances and to make clear whether special or conditional use permits will be required for facilities to operate in specific residential zones. Optimally, all municipalities should adopt a set of uniform definitions for community-based residential facilities in general conformance with State definitions.

2. If local municipalities desire further control over this type of land use then an "acceptable distance criterion" and/or a measure of "institutional density" computed at the individual facility level ought to be included in any zoning amendments enacted.

These recommendations are formulated as a means of encouraging municipalities to develop locally acceptable mechanisms for dealing with community-based residential facility zoning issues, before controversies arise. Moreover, given increasing State involvement in such matters, these recommendations argue that some local discretion be maintained in these matters.

Third, issues regarding neighborhood and "quality of life" compatibility appear to represent the core of community resistance. As discussed earlier, community reactions to persons with social disabilities can be viewed as a function of a threat to well-established beliefs as to how best to control "deviant behavior". In this regard, community education has generally been left up to various advocacy groups and to the programs themselves. While the extensive work of these organizations is not to be minimized, it is recommended that:

1. Individual State Agencies (principally the Department of Public Welfare and the Department of Corrections) make explicit to the general public through the media and relevant community organizations how policies of deinstitutionalization are being developed, how they are to be implemented (the licensing process, funding channels, and use of paraprofessionals), and what the nature of a workable community-facility relationship can be.

2. In this educational effort, stress ought not to be placed on marketing conceptual arguments such as the "continuum of care" or "normalization" principles. This role is best left to advocacy groups and to residents who are evidence that the program "works". Rather, State agencies should be making clear to affected communities the facts behind the initiation of their policies, arguing program merits on the basis of program evaluation results. It is clear that if this is not done, community resistance in the face of unpredictability and uncertainty will continue to mount, with or without State enabling legislation superseding local zoning restrictions.

Fourth, it was shown that community resistance to residential facilities reflects an underlying interest in program operations, i.e., financing, staffing, and project outcomes. The present "normalization services system" reflects a multiplicity of service delivery channels in the same geographical area and for similar services.

Given the current state-of-the-art in evaluating the efficacy of community-based residential facilities, it would appear that planners may very well wish to assume a "better mousetrap principle" in allocating resources to these programs. By encouraging competition between agencies providing overtly similar services to similar client groups, planners are encouraging program flexibility and hence, innovation in the provision of these services.

Moreover, where feasible, planners ought to encourage the development of residential programs that increasingly reflect planning inputs and control over program operations by residents and/or members of the host community. For example, in the case of chemical dependency halfway houses, many, if not most providers have had a chemical dependency problem. If we accept that the staff of these programs identify daily with the problems they have overcome, then such programs can be considered "consumer controlled".

Similarly, Model Cities and other community organizations have sponsored and monitored the activities of certain community-based facilities, and as such, these facilities can be considered "community controlled".

Finally, in the development of living-working cooperatives for former patients of mental health institutions,[53] persons are encouraged to engage in "cooperative control" of their lives and through daily activities gain independent self-control.

To these ends, it is recommended that:

> The Department of Public Welfare, working through County Welfare Departments and Area Mental Health Boards, begin to develop formal mechanisms that intervene in resource allocation to community-based residential facilities in ways which encourage, rather than discourage, competition among service providers.

An example of how such competition may be fostered is found in the Minnesota Community Corrections Act of 1973.[54] This Act encourages local counties to divert offenders from State correctional facilities to community-based programs levying a financial disincentive on a County if it utilizes a State institution. More specifically:

> Once under the Act, counties will be charged for the use of state institutions for adults whose sentences are for 5 years or less, as well as for all juvenile commitments. Coupled with the subsidy, the obvious incentive is to encourage the development and use of community programs wherever possible and state facilities only as a last resort.

Such an incentive system has the potential to encourage counties to search for residential and non-residential programs that are "most effective", i.e., lead to the least number of persons incarcerated in state institutions, and would not necessarily result in support of programs that are the least costly; a common caveat to such proposals.

Perhaps the most significant unresolved policy-related issue with respect to community-based residential facilities is the problem of <u>jurisdictional spillovers</u>.

It is clear that utilization of community-based residential facilities is regional in scope. As a result of facility service areas extending beyond municipal and county boundaries, elected officials are often hard

pressed to explain to constituents why their neighborhoods should host programs that will benefit persons from outside these areas. Residents of Minneapolis and St. Paul contend that suburbs have not borne their "fair share", and certain neighborhoods within these cities have effectively organized to prevent further development of facilities in their communities.

The existence of such jurisdictional spillovers seems to make inter-governmental cooperation essential, if issues concerning inequities in the delivery of these services are to be addressed. To this end, it is recommended that:

> A Regional Community-Based Residential Services System Task Force be established with the objective of critically examining and proposing solutions to spill-over-related issues concerning implementation of Policy 54 in the Health Chapter of the Metropolitan Development Guide: STATE AND FEDERAL AGENCIES, FOUNDATIONS, UNITS OF LOCAL GOVERNMENTS, AREA PROGRAMS, AND OTHER PUBLIC AND PRIVATE AGENCIES SHOULD BE ENCOURAGED TO EXPAND ELIGIBILITY AND FUNDING FOR SERVICES WHICH PROVIDE ALTERNATIVES TO INSTITUTIONALI-ZATION.[55]

Further it is recommended that:

> The Department of Public Welfare and Department of Corrections jointly convene such a body and provide it with high public visibility. In selecting persons to serve on this Task Force, maximum effort should be placed on creating constructive interchange between representatives of County-level government and local municipalities. Furthermore, residents of communities or neighborhoods in which facilities are located and facility operators, should be given significant representation on this body.

Alternatively, with the advent of a strong Federal commitment to health services planning, reflected in the passage of the National Health Planning and Resources Development Act (P.L.93-641), the Regional Health Systems Agency may want to consider the role it can play in resolving inter-governmental issues related to the provision of community-based residential services. With this legislation "health systems agencies" have the

As this paper has attempted to show, the growth and development of community-based residential facilities reflects a broader social policy issue--a conflict between the values of "inherent equality" and "actual productive contribution". Those who advocate deinstitutionalization policies associate themselves most clearly with the former value. While those who are entrusted with administering land use policies identify more strongly with the latter value.

The future viability of community-based residential facilities is contingent on developing formal mechanisms that will allow for the resolution of the differences between these positions, giving equal weight to the need to implement principles of normalization and the right of communities to come to grips with issues of neighborhood succession which <u>they</u> perceive as affecting their "quality of life".

Since community-based residential facilities are innovations in human services delivery, extensive documentation as to the efficacy of many of these programs has yet to be produced. As a final note, program evaluation can be viewed not only as a means for addressing questions of program efficiency and effectiveness but as a mechanism for mitigating community resistance. Evaluation represents a mechanism by which the individual program and its funding source can demonstrate accountability to both the host neighborhood and general community.

In a broader context, attention must be given to the evaluation of State deinstitutionalization policies. As Wolpert and Wolpert note with respect to the mentally ill:

> If many people continue to be hospitalized simply because they are unwanted by communities, if those released are faced with a severe decline in the quality of life, and if community preventative services fail to reduce the need for confinement, [then] the public mental health [welfare, corrections] sector will have once again failed to fulfill its mandate.[57]

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6. The "continuum of care" concept surfaced with the implementation of the Social Security Amendments of 1967 and has continued as an underlying goal of Public Law 93-647 (Title XX of the Social Security Act).

7. This chart is reproduced from an unpublished report of the Mental Health Subcommittee for Planning for Hastings State Hospital, 1974.

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14. This figure was derived from examination of Minnesota Department of Public Welfare Rule #34 applications, i.e., Standards for the Operation of Residential Facilities and Services for Persons who are Mentally Retarded, and Metropolitan Health Board certificate-of-need reviews.

15. The following community-based residential facilities have either closed or relocated during the last three years:

CLOSED	RELOCATED
in Minneapolis	in Minneapolis
Ada House	Eden House
Anishinabe Waki-Igan	Freeport West Inc.
Group Residence for Boys	House of Incarus
John R. Hauer	Indian Neighborhood Club (now non-residential)
Horizon Place	Pharm House
Hull House	
Indian Haven	
Institution for Community Continuum	
Roger A. Johnson	
Metamorphosis Inc.	
Our House	
Project Turnabout	
in St. Paul	in St. Paul
Ashland House	Granville House
Christian Brothers Group Home	Jonathon Group Home
Community Crisis Home	
Millie Hayes	
Jacobsen Transition Center	
The Mansion	
Serenity House	
Charles Spandino	
Irene Stritzke	
Unit Inc.	

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28. Memorandum of the President's Committee on Mental Retardation, Ad Hoc Committee on Codes, Standards, and the Developmentally Disabled. June 26, 1974.

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APPENDIX A

COMMUNITY-BASED RESIDENTIAL FACILITIES

Name & Address	Type of Facility	Capacity
AREA: Minneapolis - Calhoun-Isles		
*1. Aldrich Board & Care Home 3101 Aldrich Ave. S.	board and care: adults with mental health problems	25
*2. Alpha House 2712 Fremont Ave. S.	adult community corrections	14
*3. Birchwood Board and Care Home 715 W. 31st	board & care: adults with mental health problems	60
*4. Charles M. Bronstein Home 2644 Fremont Ave. S.	mentally retarded adults	10
*5. Clare Group Home 1775 Emerson Avenue S.	adolescent group home	7
*6. Emerson Board & Care Home 2708 Emerson Ave. S.	board and care: adults with mental health problems	10
*7. Freedom House #2 3020 Lyndale Ave. S.	adult community corrections/chemical dependency	13
*8. Home Away #2 3032 Emerson Ave. S.	adolescent group home	10
*9. Home Away #3 2433 Aldrich Ave. S.	adolescent group home	10
*10. Kenwood Nursing Home 2124 Dupont Avenue S.	nursing home: adults with mental health problems	35
AREA: Camden		
*1. New Life Home 5257 Emerson Ave. N.	adolescent group home	7
AREA: Central		
*1. Colonial Residence 1918 Park Ave.	adolescent group home	40
*2. Community Involvement Program 1900 Stevens Ave.	adult mentally retarded	32

Name & Address	Type of Facility	Capacity
AREA: Central/continued		
*3. Clara Doerr Residence 1717 2nd Ave. S.	adult mentally retarded	60
*4. Eden House 1025 Portland Ave.	chemical dependency	88
*5. Edmund Homes #1 420 Ridgewood Ave.	adult mentally retarded	9
*6. Edmund Homes #2 335 Ridgewood Ave.	adult mentally retarded	9
*7. Elliot Avenue Board & Care Home 1500 Elliot Ave.	board & care: adults with mental health problems	15
*8. Groveland Residence West 310 Groveland Ave.	adolescent group home	10
*9. Groveland Residence East 735 East Franklin Ave.	adolescent group home	10
*10. Groveland Terrace 15 Groveland Terrace	nursing home: adults with mental health problems	34
*11. Home Away #5 223 W. Franklin Ave.	adolescent group home	10
*12. Mansion Home 419 Oak Grove St.	board & care: adults with mental health problems	29
*13. New Hope Center for Men 212 11th Ave. S.	chemical dependency	20
*14. Nexus House 914 S. 6th St.	adult community corrections	16
*15. Oak Grove Board & Care Home 131 Oak Grove St.	board & care: adults with mental health problems	23
*16. 425 Oak Grove Street 425 Oak Grove Street	board & care: adults with mental health problems	11
*17. One Hundred Eighty Degrees Inc. 236 Clifton Ave.	adult community corrections/chemical dependency	25
*18. Outreach Community Center 1619 Portland Ave.	adult mentally retarded	108
*19. The Parkway 1501 Lasalle Ave.	chemical dependency	90

Name & Address	Type of Facility	Capacity
AREA: Central/continued		
*20. Project Re-entry 900 North 4th St.	adult community corrections	22
*21. Restitution Center 30 S. 9th St.	adult community corrections	25
*22. Salvation Army--Harbor Light Center 706 North 1st Ave. N.	chemical dependency	60 + (12 transient dorm)
AREA: Longfellow		
*1. Prodigal House 51st & Minnehaha Ave.	chemical dependency	23
*2. Project Elan 5231 Minnehaha Ave.	adult community corrections	21
AREA: Near North		
*1. Anishinabe Longhouse 1016 Newton Ave. N.	adult community corrections	15
*2. Emerson House 1523 Emerson Ave. N.	chemical dependency	16
*3. Family Affair 1001 Penn Ave. N.	chemical dependency	20-25
*4. Janitorial Aces 926-28 Russell Ave. N.	work-living cooperative: adults with mental health problems	10
*5. Lyndale North Board & Care Home 2210 Lyndale Ave. N.	board & care for adults with mental health problems	10
*6. Spotless Cleaners 1431 Knox Ave. N.	work-living cooperative: adults with mental health problems	11
*7. Zion Northside Group Home 1700 Penn Ave. N.	juvenile community corrections	10
AREA: Nokomis		
*1. Jonathon Group Home 4537 3rd Ave. S.	adolescent group home	10
*2. Midwest Challenge Girls Home 4331 15th Ave. S.	chemical dependency	5

Name & Address	Type of Facility	Capacity
AREA: Nokomis/continued		
*3. St. Josephs Home for Children 12th Ave. & E. 4th St.	child caring institution	140
*4. N. W. Williams 215 E. 48th St.	juvenile community corrections	<5
AREA: Northeast		
No community-based residential facilities		
AREA: Powderhorn		
*1. The Apartment (Three-Quarter Way) 2751 Elliot Ave.	chemical dependency	7
*2. At East Rest Home 2319 1st Ave. S.	board & care: adults with mental health problems	15
*3. Blue Star Cleaning Contractors 3536 17th Ave. S.	work-living cooperative	8
*4. Crossroads I 2741 Chicago Ave. S.	chemical dependency	13
*5. Crossroads II 2735 Elliot Ave. S.	chemical dependency	13
*6. Freedom House 3111 Harriet Ave. S.	adult community corrections/chemical dependency	7
*7. Group Home of the City 3222 16th Ave. S.	adolescent group home	6
*8. Harambe Community Group Home 3301 3rd Ave. S.	adolescent group home	10
*9. Home Away #1 2119 Pleasant ave. S.	adolescent group home	10
*10. Home Away #4 2219 Pleasant Ave. S.	adolescent group home	10
*11. Home Away #6 3103 Columbus Ave. S.	adolescent group home	10
*12. House of Icarus 2318 1st Ave. S.	chemical dependency	16

	Name & Address	Type of Facility	Capacity
	AREA: Powderhorn/continued		
*13.	Indian Guest House 3020 Clinton Ave. S. (closing 12/31/75)	chemical dependency	13
*14.	LSS Friendship House 2427 Park Ave.	child caring institution	35
*15.	Loring Nursing Home 2327 Pillsbury Ave. S.	nursing home: adults with mental health problems	49
*16.	Midwest Challenge Inc. 3045 Columbus Ave. S.	chemical dependency	10
*17.	Native American Boys Home 2446 Portland Ave. S.	adolescent group home	10
*18.	New Hope Center for Women 3125 Clinton Ave. S.	chemical dependency	5
*19.	Nu-Way House #1 2200 1st Ave. S.	chemical dependency	29
*20.	Nu-Way House #2 2518 1st Ave. S.	chemical dependency	31
*21.	Nu-Way House #3 (Three-Quarter Way) 2527 1st Ave. S.	chemical dependency	11
*22.	Park Avenue Group Home 2433 Park Ave.	adolescent group home	10
*23	Pathway Group Home for Girls 2418 Pillsbury Ave.	adolescent group home	8
*24.	Pathway Group Home for Boys 3600 18th Ave. S.	adolescent group home	10
*25.	Pillsbury Board & Care Home 2500 Pillsbury Ave. s.	board & care: adults with mental health problems	22
*26.	Pillsbury Manor 2311 Pillsbury Ave. S.	adult mentally retarded	34
*27.	Pleasantview Home 2548 Pleasant Ave. S.	adult mentally retarded	15
*28.	Progress Valley Inc. 3033 Garfield Ave.	chemical dependency	24

	Name & Address	Type of Facility	Capacity
*29.	St. Ann's Residence 2120 Clinton Ave. S.	adult mentally retarded	30
*30.	Spartan Cleaners 3639 Park Avenue S.	work-living cooperative: adults with mental health problems	11
*31.	United Indian Group Home for Girls 2525 Park Ave. S.	adolescent group home	10
*32.	Volunteers of America 2728 Portland Ave. S. (Independence House)	marginally retarded adolescents	9
*33.	Wasie Residence 2601 Elliot Ave. S.	group residence for adults with mental health problems	10
*34.	Wayside House 2401-2409 Pillsbury Ave.	chemical dependency	36
*35.	Winaki House 2408 4th Ave. S.	chemical dependency	12

AREA: Southwest

*1.	Master House Cleaners 4155 Wentworth Ave. S.	work-living cooperative: adults with mental health problems	9
*2.	Grand Avenue Board & Care 3956 Grand Ave. S.	board & care: adults with mental health problems	21

AREA: University

*1.	Bridge for Troubled Youth 608 20th Ave. S.	adolescent group home	10
*2.	Freeport West Inc. 1 27th Ave. SE	juvenile community corrections	10
*3.	Groveland Residence Southeast 705 12th Ave. SE	adolescent group home	10
*4.	Pharm House Residence 1025 6th St. SE	chemical dependency	21
*5.	Portland House 514 11th Ave. SE	adult community corrections	16
*6.	Project Newgate (Men) 1901 University Ave. SE	adult community corrections	20

Name & Address	Type of Facility	Capacity
AREA: University		
*7. Project Newgate (juvenile) 632 Ontario Street	juvenile community corrections	22
*8. Talbot Hall 2412 South 7th St.	chemical dependency	21
*9. Youth Community Sanford Hall - Univ. of Minn.	child caring institution	10

Name & Address	Type of Facility	Capacity
AREA: St. Paul - Battle Creek		
1. C. & M. Dunn 1346 S. Point Douglas Road	juvenile community corrections	⟨5
2. M. & P. Svendsen 1771 C. Street	juvenile community corrections	⟨5
AREA: Como Park		
*1. W. & K. Benner 1437 Como Avenue	juvenile community corrections	8
*2. Booth-Brown House 1471 Como Ave. W.	child-caring institution	29
*3. Hope Transition Center 1471 Como Ave. W.	halfway house: adults with mental health problems	30
AREA: Crocus Hill		
*1. Advocate House 584 Grand Ave.	child-caring institution (women's emergency services)	15
*2. Bush Memorial Children's Center 180 South Grotto St.	child-caring institution	32
*3. Grand House 1004 Grand Avenue	adolescent group home	10
*4. Nekton on Goodrich 917 Goodrich Ave.	mentally retarded adolescents	10
AREA: Daytons Bluff		
1. G. & A. Eby 458 Maria Ave.	juvenile community corrections	5
*2. Green House 680 Greenbrier St.	chemical dependency	22
*3. Maria Group Home 193 Maria Ave.	adolescent group home	6
*4. Reaney Heights 905 East 7th St.	adult mentally retarded	113

Name & Address	Type of Facility	Capacity
AREA: Daytons Bluff/continued		
5. Roth, G. & M. 700 E. 8th St.	juvenile community corrections	<5
AREA: Downtown		
*1. Friendship Hall - Towne House 235 E. 7th St.	child-caring institution	15
*2. Team House 54 W. Exchange St.	chemical dependency	32
AREA: Hazel Park		
*1. Greenbrier Home 941 Birmingham St.	adult mentally retarded	172
*2. Reitan Adult Group Home 700 York Ave.	adult community corrections	5
*3. M. & J. Sullivan 1768 Case St.	juvenile community corrections	<5
AREA: Highland Park		
*1. Hayes Haven 1620 Randolph	board & care: adults with mental health problems	20
*2. Nekton on the Mississippi 1866 South Mississippi River Rd.	mentally retarded children & young adolescents	5
AREA: Macalester-Groveland		
*1. Browndale Minnesota 1903 Grand Ave.	child caring institution	5
2. E. & J. Hary 462 S. Warwick St.	juvenile community corrections	<5
*3. Jefferson House (Browndale Minnesota) 1816 Jefferson	child caring institution	5
*4. Lincoln House 1887 Lincoln Ave.	child caring institution	6
*5. Osceola House (Browndale Minnesota) 1507 Osceola Street	child caring institution	5

Name & Address	Type of Facility	Capacity
AREA: Merrian Park		
*1. Arrigoni Inc. 1898 Dayton Ave.	chemical dependency	12
*2. Marshall House (Browndale Minnesota) 1866 Marshall Ave.	child caring institution	5
*3. New Connections #2 444 Lynnhurst Ave.	chemical dependency	15
*4. The Other House 1977 Marshall Ave.	juvenile community corrections	7
*5. Selby House (Browndale Minnesota) 1325 Selby Avenue	child caring institution	5
*6. Tri. House 1793 St. Anthony	juvenile community corrections	6
*7 Twin Town Treatment Center 1706 University Ave.	chemical dependency	42
AREA: Midway		
*1. Changes #1 1157 Sherburne Ave.	chemical dependency	10
*2. Changes # 2 1275 Sherburne Ave.	chemical dependency	5
*3. Juel Fairbanks Aftercare Residence 806 North Albert St.	chemical dependency	17
*4. Hewitt House 1593-95 Hewitt St.	halfway house: adults with mental health problems	23
*5. Leonard Marshall 1491 Sherburne Ave.	board & care: adults with mental health problems	10
AREA: North End		
*1. Arlington House for Girls 590 Arlington	child caring institution	14
2. F. & P. Horning 365 E. Hoyt	juvenile community corrections	<5

Name & Address	Type of Facility	Capacity
AREA: North End/continued		
*3. Nor-Haven Inc. 1394 Jackson St.	adult mentally retarded	110
*4. Welcome Homes Inc. 1609 Jackson St.	non-ambulatory mentally retarded children	43
AREA: Phalen Park		
*1. Arlington House for Boys 1060 Greenbrier St.	child-caring institution	20
AREA: St. Anthony Park		
*1. Group Homes Inc. (Knapp House) 2101 Knapp St.	adolescent group home	10
AREA: Summit-University		
*1. Big House Community Center 585 Portland Ave.	juvenile community corrections	22
2. Bishop, J. & C. 791 Holly Ave.	juvenile community corrections	<5
*3. Catholic Guild 286 Marshall Ave.	board and care: adults with mental health problems	75
*4. Marcella Clemens 761 Marshall Ave.	board and care: adults with mental health problems	19
*5. Dayton Board & Care 740 Dayton	board and care: adults with mental health problems	26
*6. Dayton House 565 Dayton Ave.	chemical dependency	16
*7. Directions for Youth, Inc. 1089 Portland Ave.	adolescent group home	5
*8. Ekelund Boarding Care Home #1 89 Virginia Ave.	board and care: adults with mental health problems	25
*9. Ekelund Boarding Care Home #2 102 North Western Ave.	board and care: adults with mental health problems	21
*10. Group Homes Inc. (Grand House) 1004 Grand Ave.	adolescent group home	10

	Name & Address	Type of Facility	Capacity	
	AREA: Summit-University/continued			
*11.	House by the Side of the Road 715 Dayton Ave.	juvenile community corrections	10	*
*12.	Juvenile Horizons 355 Marshall Ave. (old Seton Ctr)	child-caring institution	24	*
*13.	Kent House of People Inc. 197 N. Kent St.	chemical dependency	13	*4
*14.	Kurscher Boarding Home 529 Holly Ave.	board & care: adults with mental health problems	14	
*15.	Group Homes Inc. (Marshall House) 512 Marshall Ave.	adolescent group home	9	*1
*16.	New Connections 719 Portland Ave.	chemical dependency	15	*2
*17.	Oakland Boarding Home 97 N. Oxford	board & care: adults with mental health problems	32	*3
*18.	Lorraine Peterka 513 Portland Ave.	board & care: adults with mental health problems	18	*6
*19.	P.I. House 581 Portland Ave.	adult community corrections	14	*7
*20.	Pineview Residence 69 North Milton	board & care: adults with mental health problems	22	*8
*21.	Project Newgate (women) 341 Dayton Ave.	adult community corrections	21	*9
*22.	Retreat House 532 Ashland Ave.	adult community corrections	29	
	AREA: Thomas--Dale			
*1.	I. A. O'Shaughnessy Group Home 919 Lafond Ave.	adolescent group home	10	
2.	J & M.B. Borden 718 Charles Ave.	juvenile community corrections	<5	
	AREA: West Side			
1.	Campbell, W. & P. 283 E. Winifred	juvenile community corrections	<5	

Name & Address	Type of Facility	Capacity
AREA: West Side/continued		
*2. Esparza, E. & T. 210 E. Robie	juvenile community corrections	6
*3. Group Homes Inc. (Prospect House) 176 Prospect	adolescent group home	10
*4. Nekton on Wyoming 445 E. Wyoming	adult mentally retarded	8
AREA: West 7th Street		
*1. Bremer House 855 W. 7th St.	adult community corrections	20
*2. Fellowship Club 680 Stewart Ave.	chemical dependency	39
*3.--5. Hillman's Boarding Homes 377, 399, 403 Duke St.	rooming houses: primarily adults with mental health problems	33 (12,12,9)
*6. Hoikka House 238 Pleasant Ave.	residential facility for adults with mental health problems	117
*7. The Homestead 398 Duke	board & care: adults with mental health problems	21
*8. Shoreview Treatment Center 355 Sherman	chemical dependency	29
*9. Victory House 255 Smith	chemical dependency	23

SUBURBAN COMMUNITY-BASED RESIDENTIAL FACILITIES

Name & Address	Type of Facility	Capacity
AREA: South Minneapolis Sector (3)		
1. Outreach Home 7425 4th Ave. S. Richfield	mentally retarded adults	6
2. Seely, E. Route 2 Farmington	juvenile community corrections	4
3. Welcome Community Home 10001 Lyndale Ave. Bloomington	adolescent group home	8
AREA: Southwest Minneapolis Sector (10)		
1. Colonial Group Home 6424 Winsdale Golden Valley	adolescent group home	6
2. Community Living Inc. Box 128 Victoria	mentally retarded adults	42
3. Cooper, G.S. Group Home 110115 Friendship Lane N. Chaska	adolescent group home	8
4. Hammer School 1909 E. Wayzata Blvd. Wayzata	mentally retarded adults and children	61
5. Homeward Bound Inc. 14000 County Road 67 Minnetonka	mentally retarded children	24
6. Mt. Olivet Rolling Acres Excelsior	mentally retarded children & adolescents	70
7. Opportunity House 5730 Olson Memorial Highway Golden Valley	chemical dependency	23
8. Shannondale Farm Group Home St. Bonnifacious	adolescent group home	5
9. Way-12 645 Wayzata Blvd. Wayzata	chemical dependency	20
10. Welcome Community Home 205 South Brown Rd. Long Lake	adolescent group home	9

Name & Address	Type of Facility	Capacity
AREA: Northwest Minneapolis Sector (5)		
1. Forestview Children's Home 115 Forestview Lane N. Plymouth	mentally retarded children	14
2. His Place 1120 69th Ave. N. Brooklyn Center	adolescent group home	4
3. Outreach Home 507 69th Ave. N. Brooklyn Center	mentally retarded adults	6
4. Pioneer House 3401 E. Medicine Lake Road Plymouth	chemical dependency	27
5. Welcome Community Home - North 6451 Brooklyn Boulevard Brooklyn Center	adolescent group home	10
AREA: South St. Paul Sector (5)		
1. Dakotas Children 400 West Marie West St. Paul	mentally retarded children	44
2. Henry Hagen Residence 19845 Lillehei Marshan Township	mentally retarded adults	7
3. Ketterling, R. 1786 Bluestone Eagan	juvenile community corrections	6
4. Orvilla Inc. 3430 Wescott Hills Drive Eagan	mentally retarded adults	54
5. Watschke, J. 1782 Bluestone Eagan	juvenile community corrections	5
AREA: Southeast St. Paul Sector (4)		
1. Brewers, L. 1159 W. 15th St. Hastings	juvenile community corrections	3

Name & Address	Type of Facility	Capacity
AREA: Southeast St. Paul Sector/continued		
2. Downing, J. & M. Group Home 6568 81st Street S. Cottage Grove	adolescent group home	6
3. Homestead Group Home 12426 15th Street S. Afton	adolescent group home	6
4. Sirr Group Home 8010 Hemingway Cottage Grove	adolescent group home	8
AREA: Northeast St. Paul Sector (21)		
1. Beaver, A. & E. 6305 Gopher Ave. Oakdale	juvenile community corrections	< 5
2. Bee Dale Apartment Project (Reaney Heights Satellite) 2210 7th Ave. E. North St. Paul	mentally retarded adults	27
3. Ehnstrom, R. & S. 13434 Greenwood Trail West Lakeland Township	juvenile community corrections	< 5
4. Graf Jr., A. & J. Hugo	juvenile community corrections	< 5
5. Graf, J. & B. 11560 239 Street Scandia	juvenile community corrections	< 5
6. Granville House 430 Woodbury Drive Lake Elmo	chemical dependency	32
7. Hask, L. & B.J. 1823 Mary Joe Lane North St. Paul	juvenile community corrections	< 5
8. Hadd, D. & J. 6703 First St. N. Oakdale	juvenile community corrections	< 5
9. Held, J. & R. 2566 E. Burke Ave. North St. Paul	juvenile community corrections	< 5

	Name & Address	Type of Facility	Capacity
	AREA: Northeast St. Paul Sector/continued		
10.	Jamestown Foundation 11550 Jasmine Trail N., Stillwater	chemical dependency	24
11.	Jervis, S. & P. 2070 E. County Road F. White Bear Lake	juvenile community corrections	< 5
12.	Jesmer, M. & J. 206 Dartmoor Willernie	juvenile community corrections	< 5
13.	Johnson, T. & B. 23820 Lifton Ave. N. Scandia	juvenile community corrections	< 5
14.	Kinzer, S. & D. Marine on the St. Croix	juvenile community corrections	< 5
15.	Northeast Residence 104 Bald Eagle Ave., White Bear Lake	mentally retarded children	9
16.	Oden, C. & P. 3604 Brookview Drive Lake Elmo	juvenile community corrections	6
17.	Odenwald, L. & F. 6197 25th St. N. Oakdale	adolescent group home	6
18.	Revoir Family Group Home 6180 24th St. N. Oakdale	adolescent group home	5
19.	Rothbauer, R. & R. 2724 Spruce Place White Bear Lake	juvenile community corrections	< 5
20.	Springborn, G. & W. 8709 Demontreville Trail N. Lake Elmo	juvenile community corrections	<5
21.	Zink, N. & D. 9344 60th St. Lake Elmo	juvenile community corrections	< 5
	AREA: North St. Paul Sector (12)		
1.	Erickson, R. & J. 239 Hawes Ave. Shoreview	juvenile community corrections	6

Name & Address	Type of Facility	Capacity
AREA: North St. Paul Sector/continued		
2. Graf, Sr. A. & D. 2581 Edgerton Little Canada	juvenile community corrections	<5
3. Gruber, R. & J. 591 N. Bear Ave. Vadnais Heights	juvenile community corrections	<5
4. Hoff, J. & M. 4212 Highland Drive Shoreview	juvenile community corrections	<5
5. Home of the Good Shepherd 5100 Hodgson Road Shoreview	child caring institution	48
6. Houle, J. & M. 3101 W. Owasso Blvd. Roseville	juvenile community corrections	<5
7. Nekton on Frost 1695 Frost Ave. Maplewood	mentally retarded children	6
8. Sprandel, J. & C. 700 W. Co. Rd. B2 Roseville	juvenile community corrections	<5
9. Sweat, C. & D. 160 E. County Road B2 Little Canada	juvenile community corrections	<5
10. Tollefson, C. & B. 7056 Centerville Road Circle Pines	juvenile community corrections	<5
11. Valento, P. & F. 2575 Edgerton Little Canada	juvenile community corrections	<5
12. Verley, G. & N. 580 W. Highway 96 Shoreview	juvenile community corrections	<5
AREA: North Minneapolis Sector		
1. Bar-None Boys Ranch Anoka	child-caring institution	60

	Name & Address	Type of Facility	Capacity
	AREA: North Minneapolis/continued		
2.	Benson, A. & M.A. 1404 W. County Rd. E. New Brighton	juvenile community corrections	6
3.	Big "B" Group Home Bethel	adolescent group home	6
4.	Boerger House 10687 Verdin Coon Rapids	adolescent group home	4
5.	Community Living Inc. 2483 109th St. Coon Rapids	mentally retarded adults	24
6.	Frederickson, J. 1103 Queens Lane Anoka	juvenile community corrections	< 5
7.	Howell, W. 2738 112th Ave. N. Coon Rapids	juvenile community corrections	< 5
8.	Hughes, D. & S. 5526 St. Stephans St. New Brighton	juvenile community corrections	< 5
9.	Martin, A. & D. 2139 29th Ave. N.W. New Brighton	juvenile community corrections	< 5
10.	Miller, G. 6743 159th Ave. NW Anoka	juvenile community corrections	< 5
11.	Rimkus, E. 2670 Scotland Court Mounds View	juvenile community corrections	< 5
12.	Weber, D. 1505 Trollhogen Drive Fridley	juvenile community corrections	< 5
13.	Your Place #1 9239 Griggs Ave. N. Lexington	adolescent group home	6
14.	Your Place #2 9329 Dunlap Ave. Lexington	adolescent group home	9

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APPENDIX B

Facilities Included in Community Resistance Analysis

Name	Type	Initial Date of Review	Opposition	Outcome
1. Alpha House 2712 Fremont Ave. S. Mpls.	adult community corrections	1973	No	C.U.P. granted
2. Alpha Omega House 600-610 W. 32nd St. Mpls.	adult community corrections	1973	Yes	C.U.P. denied
3. Anishinabe Longhouse 1016 Newton Ave. N. Mpls.	adult community corrections	1974	No(at this site); had applied to 2 other locations.	C.U.P. granted
4. Anishinabe Wak-Igan 3033 Portland Ave. S. Mpls. (closed 1974)	adult community corrections	1972	Yes	C.U.P. granted
5. Blaine Construction Co. 6887 Central Ave. Fridley	adult mentally retarded	1972	Yes	C.U.P. denied
6. Circle F CLub (Hennepin County General Hospital) 2400 Pillsbury Ave. Mpls.	adult mentally ill	1974	Yes	C.U.P. denied
7. The City Inc. 3222 16th Ave. S. Mpls.	adolescent group home	1974	Yes	C.U.P. granted
8. Eden House 1025 Portland Ave. Mpls.	chemical dependency	1974	Yes	C.U.P. granted
9. Freedom Rehabilitation Re-entry Inc. a)3111 Harriet Ave. b)3020 Lyndale Ave.	adult community corrections	1974	Yes	Both C.U.P.'s granted
10. Freeport West Inc. a) 2915 Newton Ave. N. b) 6120 1st Ave. S. c) 5604 10th Ave. S. Mpls.	adolescent group home	1974	Yes	a) & b) applications withdrawn, c) C.U.P. denied.

	Name	Type	Initial Date of Review	Opposition	Outcome
11.	Groveland East 735 E. Franklin Mpls.	adolescent group home	1973	No	C.U.P. granted
12.	Groveland Southeast 705 12th Ave. S. Mpls.	adolescent group home	1974	Yes	C.U.P. granted
13.	John R. Hauer (Pathfinder Group Home) 3111 12th Ave. S. Mpls.	adolescent group home	1972	Yes	C.U.P. denied
14.	House of Icarus 4237 Tonkawood Road Minnetonka	chemical dependency	1973	Yes	C.U.P. denied
15.	House of Icarus 2318 1st Ave. S. Mpls.	chemical dependency	1974	Yes	C.U.P. granted
16.	A.D. Hull (Hull House) 2536 Aldrich Ave. Mpls.	juvenile community corrections	1973	Yes	C.U.P. granted and revoked at 1st six-month review.
17.	Indian Guest House 3020 Clinton Ave. S. Mpls.	chemical dependency	1973	No	C.U.P. granted
18.	Indian Neighborhood Club 1401 E. 24th St. Mpls. (property razed)	chemical dependency	1972	Yes	C.U.P. granted
19.	Roger A. Johnson 2806 Girard Ave. N. Mpls.	chemical dependency	1975	Yes	C.U.P. denied
20.	Jonathon Group Home 4537 3rd Ave. S. Mpls.	addolescent group home	1974	No	C.U.P. granted
21.	Juvenile Newgate 632 Ontario St. Mpls.	juvenile community corrections	1974	No	C.U.P. granted
22.	Midwest Challenge 3538 Garfield Ave. Mpls.	chemical dependency	1974	Yes	C.U.P. denied
23.	Minnesota Restitution Center 245 Clifton Ave. Mpls.	adult community corrections	1974	Yes	C.U.P. denied

	Name	Type	Initial Date Of Review	Opposition	Outcome
24.	Near Southside Receiving Center (non-residential) 2605 2nd Ave. S. Mpls.	detoxification center	1974	Yes	C.U.P. granted
25.	Nekton on Highland 3881 Hyland Ave. White Bear Lake	mentally retarded adolescents	1974	Yes	C.U.P. denied
26.	Newgate for Women 341 Dayton Ave. St. Paul	adult community corrections	1974	Yes	C.U.P. granted
27.	New Hope Center 3125 Clinton Ave. S. Mpls.	chemical dependency	1972	No	C.U.P. granted
28.	New Life Homes 3104 10th Ave. S. Mpls.	adolescent group home	1974	Yes	C.U.P. denied
29.	Nu-Way House 2518 1st Ave. S. Mpls.	chemical dependency	1972	No	C.U.P. granted
30.	One Hundred Eighty Degrees Inc. 236 Clifton Ave. Mpls.	adult community corrections	1974	Yes	C.U.P. granted
31.	Our House 2303 Pleasant Ave. S. Mpls. (closed 1975)	juvenile community corrections	1973	Yes	C.U.P. granted
32.	Outreach Community Home 7425 Portland Ave. Richfield	adult mentally retarded	1974	Yes	C.U.P. granted
33.	Pharm House 1025 6th St. SE Mpls.	chemical dependency	1972	Yes	C.U.P. granted
34.	Pleasantview Home 2548 Pleasant Ave. Mpls.	adult mentally retarded	1975	Yes	certificate-of-need review initially denied; then approved.
35.	Portland House 2421-3 Portland Ave. S. Mpls.	adult community corrections	1972	Yes	C.U.P. denied

	Name	Type	Initial Date of Review	Opposition	Outcome
36.	Portland House 514 11th Ave. SE Mpls.	adult community corrections	1972	No	C.U.P. granted
37.	The Residence 935 Amble Road Shoreview	adult mentally retarded	1974	Yes	C.U.P. granted; court litigation, C.U.P. upheld.
38.	Rolling Acres 413 8th Ave. SE Mpls.	mentally retarded/ autistic children	1975	Yes	MHA awarded land to competitive bidder.
39.	St. Stephens Lutheran Church 8450 France Ave. Bloomington	adult mentally retarded	1975	No	C.U.P. granted
40.	Salvation Army--Harbor Light Center 706 1st Ave. N. Mpls.	chemical dependency	1974	Yes	C.U.P. granted
41.	Volunteers of America 2728 Portland Ave. Mpls. (now services mentally retarded adolescents)	adult community corrections	1973	No	C.U.P. granted
42.	Volunteers of America 2632 Ferry St. Anoka	mentally retarded adults	1972	Yes	C.U.P. denied
43.	Wayside House 2401-9 Pillsbury Ave. Mpls.	chemical dependency	1973	No	C.U.P. granted
44.	Welcome Community Home 10001 Lyndale Ave. S. Bloomington	adolescent group home	1975	Yes	C.U.P. granted
45.	Winaki House 2408-10 4th Ave. S. Mpls.	chemical dependency	1974	No	C.U.P. granted
46.	Zion Northside Group Home 1700 Penn Ave. N. Mpls.	juvenile community based corrections	1973	No	C.U.P. granted

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Community Based Residential Facilities in the Twin Cities...

In recent years the concept of community care as an alternative to traditional institutions has become increasingly important. Some professionals suggest that the

> . . . movement toward deinstitutionalization and community care has been spurred on by the increasing awareness among professionals that generally large institutions have not worked; they have not, in the case of the mentally ill, helped people get well; they have not, in the case of the mentally retarded, helped people to learn and improve their functioning; nor in the case of offenders, have they taught them to lead non-criminal lives.[1]

Community-based Residential Facilities, as an alternative living and therapeutic arrangement, can be conceived as part of a "normalization services system". Proponents of deinstitutionalization point to the need for *normalization* and *continuum of care* services. Normalization services would involve people who have traditionally been faced with institutionalization in a supervised setting where "patterns and conditions of everyday life . . .are as close as possible to the norms and patterns of the mainstream of society."[2]

Availability of a continuum of care network providing the support services needed to equip these people for independent living or a return to mainstream society is an essential complement to normalization services.

Community response is an essential element in the movement toward deinstitutionalization. Are communities willing to accept a residential facility? Why should they?

Planning meetings with a community-based residential facility on the agenda have exposed the lack of information about these facilities. Proponents and opponents have had no common data on which to base discussion. One of the most significant deficiencies has been the absence of an inventory of the number and type of facilities already in place in the Twin Cities Metropolitan area.

In summer 1975 the Center for Urban and Regional Affairs started a preliminary study of the community-based residential facilities in the Twin Cities area. The study was designed to determine how many and what types of facilities are operating in the area and to investigate the process which determines the location of these facilities. One of the central questions addressed during the study was "Has some undefined system been active in the facility locational process?"

The study report issued by CURA in December 1975 points to the absence of a well designed system characterized by an evident rational process — the situation is such that a number of independent and uncoordinated actions are aggregated to determine both the type and location of a facility.

City records, primarily hearing records, provided much of the basic data for the study. Because of its impact on locational decisions and its potential influence on the future of the facility, community response was given major emphasis.

One of the basic insights of the report is the significance of the perspective — metropolitan, municipal or neighborhood — from which the community-based facility is viewed. The problems of conflicting perspectives are evident in the report documentation.

The report has been organized to provide basic reference material for policy makers, program administrators and community organizations. The authors feel that material in the report will be helpful in clarifying the issues involved in establishing community-based residential facilities and hope that the report will aid in the development of a reasonable system for handling community-based residential facilities.

For copies of the full report send a $2.00 check (made payable to the University of Minnesota) to CURA, 311 Walter Library, University of Minnesota, Minneapolis, MN 55455.

INVENTORY OF FACILITIES

247 community-based residential facilities in the Twin Cities Metropolitan area have been identified and classified. Map 1 provides an overview of the relative locations of facilities within the 7-county area. Considerable functional overlap exists between facilities categorized as "adolescent group home", "child-caring institutions" and "juvenile community corrections". Facilities currently receiving primary financial support through the Governor's Commission on Crime

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[1] Lauber, D. and Bangs, F.S. "Zoning for Family and Group Care Facilities," *American Society of Planning Officials Planning Advisory Service Report #300.* Chicago, Illinois, 1974.

Innovations in the delivery of human services are one of the on-going concerns of the Center for Urban and Regional Affairs. This issue of the CURA Reporter summarizes the preliminary study of Community Based Residential Facilities in the Twin Cities Metropolitan Area: Location and Community Response by Alan S. Friedlob and Thomas L. Anding.

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[2] Bengt, N. "The Normalization Principle and its Human Management Implications," in *Changing Patterns In Residential Services for the Mentally Retarded.* (Washington, D.C.: President's Commission on Mental Retardation), 1969.

Prevention and Control (L.E.A.A. funds), Ramsey County Community Corrections appropriations, or Anoka and Dakota County Court Services have been classified as "juvenile community-based corrections". For example, Zion Northside Group Home is licensed under DPW Rule #8 (adolescent group home) but receives its primary funding through the Governor's Commission on Crime Prevention and Control. It has been classified as a "juvenile community-based corrections" facility, not as an "adolescent group home".

"Child-caring institutions" represent facilities which primarily serve emotionally-disturbed children and juveniles with behavioral problems. A child-caring institution is distinguished from a group home on the basis of the intensity of its therapeutic program or the scale of its operations, i.e., having greater than 10 residents.

The inclusion in this study of board and care homes serving adults with mental health problems reflects their impending licensing under the Department of Public Welfare's Rule #36. Those board and care homes that acknowledge serving adults with mental health problems were included. For the most part, these facilities are certified as Intermediate Care Facilities under Title XIX (Medicaid). Additionally, many boarding and rooming houses located in the same geographical areas as these homes have significant numbers of residents with histories of mental illness. The extent to which this is the case, however, awaits further study.

The most extensive development of community-based residential facilities has occurred during the last three years. Data about when program operations began was obtained for 83 percent (163) of 196 facilities, excluding the 51 juvenile community corrections group homes supported by Ramsey, Dakota, and Anoka Counties. Approximately 55% of the 163 facilities (95) began operations between 1974 and 1975. It is important to note that only 13 new facilities began operation in 1975, contrasted with 30 new programs in 1974. Moreover, one-third of the facilities that began operation in 1975 are attributable to one operator; Brownsdale, Minnesota (childcaring institution for emotionally-disturbed children).

Prior to 1972, the predominant types of community-based residential facilities were: 1) the board and care home; 2) institution-like residences serving mentally retarded children; 3) apartment-like residences serving mentally retarded adults; 4) a few group homes and child-caring institutions administered by private social service agencies; and 5) a few halfway houses for alcoholic persons adhering to an Alcoholics Anonymous treatment model. 1972 through 1975 witnessed the emergence of community-based corrections programs, a variety of chemical dependency programs serving the needs of special target groups, and a burgeoning in the number of adolescent group homes. This growth can be attributed to an availability of federal funds, particularly in the areas of chemical dependency and corrections, and to foundation seed money support.

During the period from 1972 to 1975, 29 facilities either closed or changed their location. 19 of these 29 facilities were located in South Minneapolis (13) and Summit-University (6) areas. Among the 22 facilities that closed, adolescent group homes (7) and juvenile community corrections facilities (7) predominate. Seven facilities, including five chemical dependency facilities, changed location and are still operating. Certain homes once vacated remained in a "community-based residential facilities market" and were subsequently occupied by another residential program.

Some Implications of Facility Clustering

Facility clustering patterns exist. It can be assumed that the proximal location of similar and dissimilar target groups may have both positive and negative client-related effects. For example, the area bounded by Pillsbury, Franklin, 26th Street and 35W has six chemical dependency halfway houses representing four different programs. Such a situation is potentially conducive to the sharing of professional services. As an example, one job counselor could be hired to serve client needs at all six facilities.

Similarly, four residences for mentally retarded adults are located on the fringe of downtown Minneapolis. Location of a sheltered workshop at one of these sites, proximal to the other three residences, represents an additional example of a positive client-related locational effect. In such a situation, implications for shared transportation services are also evident.

In contrast, the hypothetical location of a home for mentally retarded adults in proximity to a juvenile community-corrections residence may be associated with negative client-related effects. A value judgment is implied in this statement. In such a situation, the potential for victimization of mentally retarded persons is *assumed* to be high. Further research is needed to confirm the validity of such assumptions and to investigate further what the positive and negative interactive effects are between similar and different types of facilities located near one another.

A related question also merits examination: what are the relative advantages and disadvantages for particular target groups of inner-city versus suburban residential facility locations? For example, in the case of chemical dependency halfway houses, should access to a lower-skilled job market, such as a day labor pool, be considered an important criterion in evaluating site selection? Or, does "psychological distance" aid recovery, such that chemically dependent persons would rather seek care *outside* their immediate neighborhood or away from areas with high drug use?

As yet, these questions of the user-associated effects of facility location are unanswered. Meanwhile 95 new facilities began operations within the last 3 years. Associated with this development are *neighborhood impact effects* that for the most part have also gone unstudied. In the following section the phenomenon of community resistance to residential facilities is examined. It is argued that an inherent structural conflict exists between the planning and allocation of resources to community-based residential facilities at the county and regional level *and* local municipal attempts to control the development of these facilities through land use and zoning practices. As will be shown, the issues surrounding the location of community-based residential facilities not only reflect a conflict between levels of government in defining jurisdictional responsibilities, but raise broader questions concerning equity in public investment and human valuation.

Community Resistance

Those who advocate establishing community-based programs for a particular target group are asking that a neighborhood absorb these persons into its social fabric. However, community-based residential facilities are generally regarded as "noxious facilities"; operations generally acknowledged by all as needed, but not necessarily desired by the residents at any potential site.

Examination of who decides when a public facility, e.g., community-based residential facility, is "noxious" and by what criteria, is central to addressing pragmatic policy issues concerned with the spatial distribution of these facilities. At least five different participants are involved in the process of establishing a community-based residential facility. These participants are: 1) property owners adjacent or proximal to the proposed facility; 2) the "broader community" surrounding the facility; 3) various

bureaucratic constituencies and elected officials impacting upon the operations of the facility; 4) the residential facility owner, operator, or program director; and 5) persons who will reside in the facility and/or advocacy groups organizing to establish facilities in behalf of these persons. It is important to bear in mind that the goals of these groups are distinctly different.

The primary social conflict revealed in the locational decision concerning group homes and halfway houses is between two values which have been referred to as "inherent equality" and "actual productive contribution". "Inherent equality" assumes that all individuals have equal claims to entitled societal benefits regardless of the quantity or quality of their contribution. "Actual productive contribution" posits that individuals who produce more output — measured in some meaningful way — have a greater claim to societal benefits than those producing less.

Community-based residential facilities have as a goal the assimilation of both the physical structure and residents' social behavior into the everyday community life of the surrounding neighborhood. The "inherent equality" value is embodied in this goal of community integration. However, the "actual productive contribution" value emerges in a variety of ways to provide the primary rationalization for neighborhood opposition to community-based residential facilities.

Analysis of Location Decisions

46 community-based residential facility locational decisions were examined to determine the frequency of different arguments used by individuals and organized community groups to oppose the location of a facility in their neighborhood.

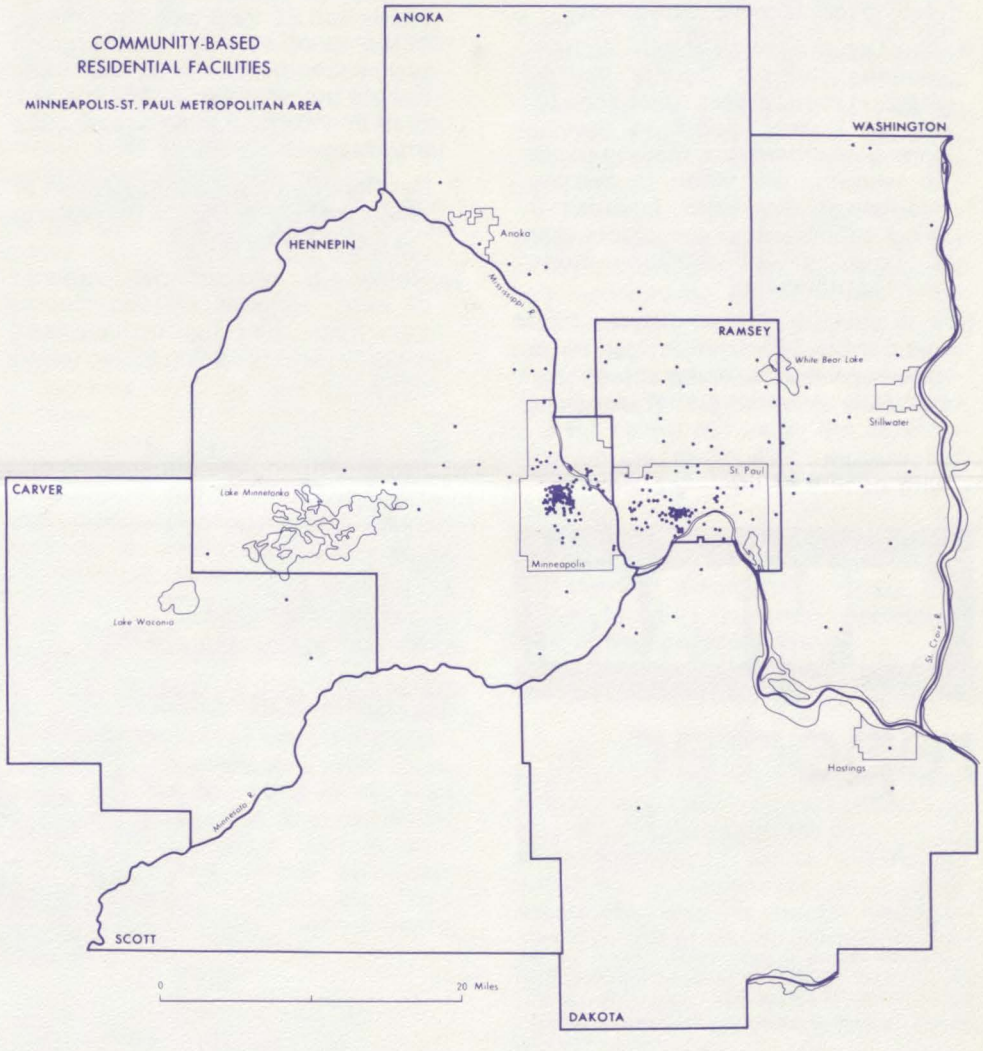
Three general observations can be made from this analysis. First, it appears that no type of community-based residential facility escapes opposition. Neighborhood residents do not positively discriminate between the persons who will occupy the home. For example, homes for both mentally retarded children and ex-offenders are as likely to encounter resistance although different arguments are invoked to buttress the opposition. While such resistance may differ in intensity, the intent is identical.

Second, if the facility can withstand a community's initial antagonisms, its survival, barring financial failure, is seemingly assured. In only one case examined was a conditional use permit revoked as a result of organized community opposition. However, initial opposition from organized community groups can act to significantly influence the growth of group homes and halfway houses, i.e., the denial of conditional use permits. Proposed facilities ought not to ignore the impact of key informal community leaders, whether or not contact with these persons and groups is mandated by local zoning or licensing officials.

In cases reviewed where there was no opposition encountered, the residential operator had gained the support of key community organizations. Often the facility had been operating in the neighborhood for some time before application for the conditional use permit was made. In cases where conditional use permits were granted and community opposition was evident, such opposition tended to be unorganized. These facilities were usually able to mobilize the support of professional groups which offset the effects of unorganized community opposition.

Finally, an interesting transition process is observed in examining what group homes and halfway houses were *before* residential facility use occurred. In many cases property use was already institutional in character, i.e., nursing home, board and care home, convent house, office building, or catered to transient occupants, i.e., rooming house, sorority or fraternity house. In this regard, the prior use of the residence would seem to indicate little or no chance of transition to single-family occupancy status. Rather, the only things overtly changing in this land use transition are the characteristics of the occupants as perceived by a segment of neighboring residents.

A related issue that should be examined is the housing transition process that occurs when a community-based residential program ceases operations. As noted earlier, preliminary evidence in the Twin Cities indicates that many of these facilities remain in a "residential facilities housing market", i.e., new residential programs assume occupancy. Yet, homes do convert back to single-



family and multiple-family use. Further investigation into the extent of this reconversion and the characteristics of the new occupants appears warranted, particularly in light of the relationship between the growth and development of community-based residential facilities and issues of neighborhood succession.

Data used in the analysis were generated through planning memoranda and zoning decisions obtained from the planning and zoning departments of Minneapolis, St. Paul, and seven suburban Twin Cities municipalities.

The range of facilities covered in terms of geographic distribution, facility type, and stage of operation (already operating, attempting to occupy an existing structure, or negotiating for the right to use a parcel of land to construct a new facility) lead the authors to believe that findings are representative of arguments used to rationalize opposition to community-based residential facilities and have generalizability in this regard.

149 negative arguments were identified in the analysis and classified into four types:

1. *Property values/economic:* including a) "property devaluation" and b) "erosion of neighborhood tax base". (10 percent of responses) [15]
2. *Land use compatibility:* including a) "density of area"; b) "already too many in the area"; c) "availability of property elsewhere" (fair share argument); and d) "zoning incompatibility leading to flooding of other noxious facilities". (24 percent of responses) [36]
3. *Neighborhood quality of life compatibility:* including a) "safety of children and elderly"; b) "lifestyle of residents"; and c) "interference with quality of life", "housekeeping matters" (parking, traffic, property maintenance) (39 percent of responses) [59]
4. *Program evaluation:* including a) "lack of supervision of residents"; b) "not enough space for facility to operate effectively"; c) "qualifications or program staff"; and d) "financing of program". (27 percent of responses) [39]

Investigation of community responses during locational decision indicates a strong community interest in issues of residential services planning. *Presently, neighborhoods appear to view deinstitutionalization policies as thrust upon them, with the source of authority for these policies ill-defined. Such ambiguity leaves many of the locational and programmatic decisions regarding these facilities unjustified.* While advocacy planning efforts have been initiated to assist potential and current facility operators to gain a foothold in a community, little has been done to systematically work with community groups in a similar advocacy style.

Human services planners have imposed on various communities and neighborhoods a set of values — deinstitutionalization is a desirable goal and community-based residential facilities are an expeditious means to this end. However, little appears to have been done to work with affected citizens groups on an on-going *basis* to involve these persons, for instance, in devising an equitable facilities distribution plan. It appears that planners have chosen to play, on a case-by-case basis, a broker role between the facility operator and a potentially hostile community. It seems that those who have been involved in these conflicts have yet to mobilize interested citizens on a broader level to confront neighborhood succession issues related to deinstitutionalization.

Community residents may be caught in a clash of interests between their own desires to protect the integrity of what they define as "community standards" (the actual productive contribution value), and the desire to be responsive to more powerful segments of society, i.e., government and church, who state that deinstitutionalization is both necessary and desirable (the inherent equality value). The implications of this dissonance with respect to understanding planning issues related to urban social change requires further explanation.

Although the "continuum of care", "normalization", and "transition" principles have become established human services planning concepts, a critical planning problem lies not only in defining the dimensions of the target populations (how many persons with certain socio-demographic characteristics having what extent of social disability) but in designing effective and efficient residential programs *carefully matched with* identifiable client needs.

Program need determination and subsequent funding support generally involve county-level negotiations, however, issues concerning location are not the direct concern of this level of government. Thus, as noted earlier, *an inherent structural conflict between county control over the allocation of resources and local municipal land use control appears evident.*

In public hearings held in December 1973 to consider proposed revisions in St. Paul's zoning code, a community representative noted:

> . . . these organizations are routinely locating in this area [Summit-University] far in excess of the needs of the community and in fact this excess is resulting in changing the character of this area from what it presently is — a residential area — to an institutional area.

From the perspective of community-based facility opponents, the fundamental issue is what kind of protection can be given the neighborhood such that its residential character can be retained? From a more conceptual point-of-view, an underlying dilemma is how to define the characteristics of a "normal residential neighborhood"?

A North Minneapolis community group in voicing its opposition to an adolescent group home noted:

> The problem is metropolitanwide and until the suburbs share the concern, we do not feel that the cities of Minneapolis and St. Paul should carry the entire burden. North Minneapolis has enough problems in maintaining our neighborhoods without taking on more. We sympathize with our South Minneapolis neighborhoods where the majority of these houses and homes are concentrated.

In contrast, the suburban case more clearly reflects issues related to the general purposes of zoning — to regulate and control the use of land so as to insure the health, safety, morals, convenience and general welfare of the residents of the area in question. Often in the suburban case, the community-based residential facility is viewed as a precursor to the intrusion of more noxious forms of land use which may also require issuance of conditional or special use permits or the granting of zoning variances, e.g., double bungalows, townhouses, or apartment buildings in areas zoned single-family residential. Moreover, newly constructed community-based residential facilities in suburban areas have been perceived as potential "white elephants" should the program cease operation. For example, if three cottages, to be occupied by mentally retarded persons, are built on a large suburban lot and the program should close, what will become of those residences? How will they be able to enter the suburban housing market?

The Cost Efficiency Question

Consideration in planning of the essential linkages between the community-based facility and relevant support services is crucially important in considering whether policies of deinstitutionalization are likely to result in cost *reduction* or merely cost *redistribution.*

A simple comparison of community residential per diem rates with

institutional rates does little to take into account the costs associated with providing requisite support services that are critical to the success of community re-integration efforts.

Earlier discussion focused on difficulties related to allocating resources to community-based residential facilities on the basis of needs assessment. Alternatively, the present "normalization services system" represents a situation in which significant competition can be assumed to exist between programs for residents. The optimal allocation of resources for community-based residential facilities might be better left to the market as a reflection of *client demand,* rather than to professional definitions of need.

As reflected in utilization patterns, it is apparent that demand for community-based residential facilities is regional in scope. While the authors were unable to conduct a comprehensive client-origin study, it is clear that the service area of an individual residential facility often exceeds a single county or municipal boundary. Host-county purchase-of-service agreements, under the Department of Public Welfare administered Title XX, provide significant fiscal support to such inter-county placements. To what extent the small scale of many facilities allows them to confine client pools to a specific geographical area, or whether the specialized nature of the services provided coupled with a program's reputation results in facilities drawing clients from a widespread area, is a question requiring further investigation.

A critical question regarding future planning of residential facilities is — should the determination of what residential needs are worth meeting and at what cost be worked out in a "residential services market-place" through an inter-play of supply and demand?

The State of Minnesota allows licensed residential facilities to be operated for profit. Such a situation begs a question requiring further investigation: Are there any differences between not-for-profit and for-profit community-based residential facilities within a given facility type, particularly with respect to the characteristics of the persons served or the treatment modalities employed?

The Control Setting

The attempt to generate a zoning program for equitable distribution of community-based residential facilities spotlights the necessity for determining the appropriate geographical perspective for facility planning. The authors of this report investigated the current jurisdictional implications of state, metropolitan and local zoning authority in terms of community-based residential facility applications.

Lack of clear-cut planning criteria for the equitable distribution of community-based residential facilities and difficulty in identifying who is responsible for such planning has led at various times to calls for a "moratorium" on all new facilities in both St. Paul and Minneapolis. In light of State policies and statutes encouraging deinstitutionalization, the legality of any local moratorium would be questionable. In *Hepper vs. Town of Hillsdale,* the New York State Court ruled:

. . . It can be safely said that the state has an abiding interest in the control and rehabilitation of addicts and in furtherance of that interest has legislated an extensive and comprehensive program including the use of qualified private facilities . . . The Town of Hillsdale takes the position that drug and narcotic addiction is a social evil and its ordinance is salutory in that it combats such evil. However, little argument is required after a comprehensive and sympathetic reading of the ordinance, to conclude that the thrust and import of the act is not to regulate or control a drug rehabilitation center in the Town but to *prohibit* such centers from operating. *The purpose of the ordinance is obviously inconsistent with the organic law of the state, and therefore, is unreasonable, arbitrary, and oppressive to a valid state purpose . . . such legislation cannot be so oppressive in nature so as to remove the Town from participation in an overall state program.*

In striking down a local ordinance expressly prohibiting the establishment of a chemical dependency halfway house, the Court, however, offered no guidance to the local municipality on how it could act to control the distribution of these facilities. *By implication, if state policies are encouraging deinstitutionalization, then the state should assume a more visible and active planning role in the development of these facilities.*

The primary difficulty in developing a neighborhood-level institutional density measure is its implementational feasibility. Assuming a quarter-mile radius restriction and the combined number of persons to be served by both the proposed and existing facilities located within this radius set at less than ten percent of the total number of persons residing within the radius, it is readily apparent that for each proposed facility a different population base would have to be computed. While this might not be particularly difficult in communities with few facilities, situations such as in South Minneapolis or Summit-University would make such calculations burdensome. In all likelihood, radii would not be coterminous with census tracts, and calculations would have to be performed on a block by block basis.

Implications of controlling over-concentration through this approach are significant for planning purposes. Utilizing acceptable distance zones will discourage single facility operators and encourage residential operators who can realize economies of scale through the administration of multiple facilities.

A complementary approach to density control would be to couple the quarter-mile restriction with control of square footage requirements at the individual facility level. Such an approach would weight residential districts differently to take into account the differential absorption capacities of high density versus low density residential districts. The acceptable distance criterion would thus control residential density at the neighborhood level, while reasonable square footage requirements would assure adjacent and proximal neighbors that the facility does not represent an instance of overcrowding.

In developing model zoning legislation with respect to the community-based residential facility, four issues need to be addressed — how are these facilities to be defined, what will be the extent of their permitted versus conditional use, how is over-concentration to be controlled, and in what ways can a community integration or citizen participation requirement be made a provision of the zoning ordinance?

Report Recommendations

1. A study be concluded to answer the question: Does a *clustering* of community-based residential facilities have a negative impact on surrounding property values?
2. Local municipalities move to explicitly define this type of land use in their local zoning ordinances and to make clear whether special or conditional use permits will be required for facilities to operate in specific residential zones. Optimally, all municipalities should adopt a set of *uniform definitions* for community-based residential facilities in general conformance with State definitions.

   If local municipalities desire further control over this type of land use then an "acceptable distance criterion" and/or a measure of "institutional density" computed at the individual facility level ought to be included in any zoning amendments enacted.

3. Individual State Agencies (principally the Department of Public Welfare and the Department of Corrections) make *explicit* to the general public through the media and relevant community organizations how *policies of deinstitutionalization are being developed, how they are to be implemented* (the licensing process, funding channels, and use of paraprofessionals), and *what the nature of a workable community-facility relationship can be.*

   In this educational effort, stress ought not to be placed on marketing conceptual arguments such as the "continuum of care" or "normalization" principles. *This role is best left to advocacy groups and to residents who are evidence that the program "works".* Rather, State agencies should be making clear to affected communities the facts behind the initiation of their policies, arguing program merits on the basis of program evaluation results. *It is clear that if this is not done, community resistance in the face of unpredictability and uncertainty will continue to mount, with or without State enabling legislation superseding local zoning restrictions.*

4. The Department of Public Welfare, working through County Welfare Departments and Area Mental Health Boards, begin to develop formal mechanisms that intervene in resource allocation to community-based residential facilities in ways which encourage, rather than discourage, competition among service providers.

5. A Regional Community-Based Residential Services System Task Force be established with the objective of critically examining and proposing solutions to spill-over-related issues concerning implementation of Policy 54 in the Health Chapter of the Metropolitan Development Guide: STATE AND FEDERAL AGENCIES, FOUNDATIONS, UNITS OF LOCAL GOVERNMENTS, AREA PROGRAMS, AND OTHER PUBLIC AND PRIVATE AGENCIES SHOULD BE ENCOURAGED TO EXPAND ELIGIBILITY AND FUNDING FOR SERVICES WHICH PROVIDE ALTERNATIVES TO INSTITUTIONALIZATION.

   The Department of Public Welfare and Department of Corrections should jointly convene such a body and provide it with high public visibility. In selecting persons to serve on this Task Force, maximum effort should be placed on creating constructive interchange between representatives of County-level government and local municipalities. Furthermore, residents of communities or neighborhoods in which facilities are located and facility operators should be given significant representation on this body.

6. Community Residential Services Boards be established in Minneapolis and St. Paul with the primary objective of *working in an ongoing manner* with residential facilities toward the goal of community integration. Principal activities of such a body could include:

   1. Developing location plans aimed at redistributing facilities throughout the city. [Planning Role]
   2. Maintaining an up-to-date register of vacant residences suitable for occupancy as community-based residential facilities. [Facilitator Role]
   3. Assessing the relationship between the facility and its neighborhood context, addressing the question: *What can the facility and the neighborhood offer each other?* [Broker and Evaluator Roles]

As this report attempted to show, the growth and development of community-based residential facilities reflects a broader social policy issue — a conflict between the values of "inherent equality" and "actual productive contribution". Those who advocate deinstitutionalization policies associate themselves most clearly with the former value. While those who are entrusted with administering land use policies identify more strongly with the latter value.

The future viability of community-based residential facilities is contingent on developing formal mechanisms that will allow for the resolution of the differences between these positions, giving equal weight to the need to implement principles of normalization and the right to communities to come to grips with issues of neighborhood succession which *they* perceive as affecting their "quality of life."

Since community-based residential facilities are innovations in human services delivery, extensive documentation as to the efficacy of many of these programs has yet to be produced. As a final note, program evaluation can be viewed not only as a means for addressing questions of program efficiency and effectiveness but as a mechanism for mitigating community resistance. Evaluation represents a mechanism by which the individual program and its funding source can demonstrate accountability to both the host neighborhood and general community.

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